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ABSTRACT

Corporate strategies that can be used in continuing nursing education programs are discussed, based on the Regional Action for Continuing Education in Nursing Education project. Attention is focused on strategies employed at Southern State University (SSU). A practical planning method was used to guide the process of corporate strategy formulation in the SSU continuing nursing education program. This method, which is used by executives in medium-sized and small companies, involves six steps: record the current strategy, determine existing problems, discover reasons for the problems, consider alternatives to solve the problems, evaluate the alternatives, and choose a new strategy. Forms that will aid in data collection and financial information on the nursing programs are appended. Sixteen fact sheets on the the regional project are attached. Topics include: gerontological nursing, a consortium approach to statewide assessment of continuing education needs, historical information on regional action for continuing education in nursing, program evaluation, delivery and program models, statewide planning for continuing nursing education, contracting as a means of provider survival, associate degree programs, and the continuing education unit. (SW)

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# STRATEGY PLANNING IN CONTINUING NURSING EDUCATION

**Eula Aiken**

**Southern Regional Education Board**
1340 Spring Street, N.W. • Atlanta, Georgia 30309 • 1982

NE 017 043

# Foreword

*Regional Action for Continuing Education in Nursing* is a three-year project funded by the Division of Nursing, U.S. Department of Health and Human Services (PHS NU-24062) and administered by the Southern Regional Education Board (SREB). It is designed to improve the quality and availability of continuing education for nurses in the South. A series of workshops has been chosen as the means to help directors of college-based continuing nursing education programs improve their skills in planning, implementing, and evaluating cost-efficient offerings.

This publication presents some ideas and techniques of corporate strategy that can be used in the "business" of continuing nursing education programs. It is based on content presented at regional workshops held during the second year of the project period. The workshop leaders discussing business management strategies were: James Lang, Associate Professor, College of Business, University of Kentucky (Lexington); Jon M. Shepard, Professor and Chairman, Department of Business, University of Kentucky (Lexington); John Taylor, Business Management Consultant (Atlanta). The workshops, and this publication, were designed to help directors maintain an awareness of the benefits of a master strategy in continuing nursing education programs.

Eula Aiken, Project Director
Audrey F. Spector, Program Director

Spring 1982

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# Introduction

Continuing nursing education programs are small businesses— they distribute services to the public, operate in a market situation and within financial constraints, and require cash flows and margins. Although profits that can be distributed to private owners may not be a concern of continuing nursing education programs, directors are interested in revenues and costs, specifically greater revenues than costs. Thus, programs become very similar to business profit centers.

The manager of a business deploys the resources of the business in a way that meets the needs of the respective environment most effectively. Similarly, the directors in continuing nursing education programs deploy cost-efficient and quality offerings to meet the needs of targeted groups most effectively. Both, therefore, need a comprehensive long-range plan or strategy. Although each will tailor a planning system to meet the unique needs of the situation, both decision-makers will use approximately the same generic process. The hypothetical situation that follows illustrates this process.

# Strategy Planning in Continuing Nursing Education at SSU

Nursing is one of several disciplines offered at Southern State University (SSU). The College of Nursing, established 10 years ago, has three programs—undergraduate, graduate, and continuing education. SSU awards the baccalaureate, master's, and doctoral degrees and continuing education units upon satisfactory completion of learning requirements in the respective program. SSU, located in a major city of the South, is recognized as a national teaching, research, and service center.

The continuing nursing education program has experienced relative success during its six years of operation. It is staffed by two full-time and one part-time faculty, a full-time secretary, and the director. Changes in the leadership of both the College of Nursing and the continuing nursing education program have prompted an analysis of the program's mission and goals. In addition, recent forecasts regarding budgeting and enrollment have reinforced the need for clarification of the continuing education program's "fit" in the College of Nursing.

The three programs in the College of Nursing have attained a good niche in the state and region. Enrollment has never been a major problem. Marketing activity, as such, has been minimal. During the past year the program presented 400 six-hour days (2400) with an average enrollment of 20 people for an average fee of $30 per day. (A statement of income and expenses is in Appendix A.)

SSU has a strong market share and a quality image. The primary concern of the director of the continuing nursing education program is maintenance of this position in view of recent budgetary forecasts. The director believes an examination of the approaches used in the program is timely. In the director's opinion, similarity to a small business points to adaptation of corporate strategy concepts to assure survival of the continuing nursing education program. A professor in the College of Business at SSU has agreed to be the consultant for a series of workshops to help faculty become familiar with pertinent corporate strategy and marketing concepts.

A corporate strategy is defined as a set of goals and policies that clarify the direction of a company. It is a vital ingredient in determining the future of a company. A strategy plan is based on forecasts, not existing conditions, and relates to the company's efforts in a particular future environment. The corporate strategy demands that managers react to environment change, i.e., analyze their environments and locate resources appropriately in that environment. Too often, deans and directors fail to recognize and/or react to changes in the environment surrounding their programs. In some cases the results have been disastrous.

The consultant used a practical planning method to guide the process of corporate strategy formulation in the continuing nursing education program at SSU. This method, used by executives in medium-sized and small companies, involves six steps.

### Step 1 Record the Current Strategy

The first step in the process of strategy formulation is *recording the current strategy*. The consultant informed the group that some businesses, especially small businesses, operate with loosely defined strategies. The importance of recording the strategy, the consultant emphasized, is to clarify top management's ideas about the kind of company it wishes to operate and the kind of company it thinks it should operate.

> *In order to describe and record the current strategy in the continuing nursing education program at SSU, the staff will complete a program analysis. (In business this analysis is called an "industry analysis.") The analysis includes an assessment of the program—its mission, objectives, and "fit" within the College of Nursing, and of the operating environment—growth patterns, types of buyers, categories of offerings, types of providers, characteristics of successful and unsuccessful providers, marketing methods (promotion and pricing), potential substitutes for the program, and the availability of funding, faculty, and facilities. Samples of forms that will aid in the collection of data are in Appendix B.*

The program analysis, advised the consultant, will help the staff in the continuing nursing education program clarify the values and concepts of social responsibility that administrators in the College of Nursing had about the delivery of continuing education to nurses.

The analysis will also help the staff become more familiar with their "competitors" in the target areas served by the SSU program. The intensity of competitive rivalry in continuing education probably varies from one location to another, but, the consultant noted, it is not overly intense in most places. However, if the demand for continuing education decreases, competition will become more intense. This situation can be aggravated further if a program is forced to continue the delivery of services that are not financially rewarding.

A core aspect of strategy formulation, according to the consultant, is the positioning of the program in the target areas so that it takes maximum advantage of the characteristics that distinguish it from its competitors.

> *It is essential that the SSU continuing nursing education program staff identify all other providers (and potential providers), determine which markets to avoid, know the strategic moves of all competitors and how seriously to take these moves.*

Too often, managers believe their competitors cannot be analyzed or that they know enough already about the competitors because of daily competition. Both assumptions, the consultant told the SSU group, are false.

Knowledge of the strengths and weaknesses of other providers will help the continuing nursing education program avoid certain pitfalls. In analyzing the competitors, the consultant suggested the following questions:

Is the competitor satisfied with its current position?

What likely moves or strategy shifts will the competitor make?

Where is the competitor vulnerable?

What will provoke the greatest and most effective retaliation by the competitor?

The consultant spent considerable time discussing some of the underlying values associated with competition and the application of this concept in a university setting.

*Some members of SSU faculty may have difficulty accepting the notion that SSU's continuing nursing education program* has *"competitors" or* is *a "competitor" in the city and state. Certainly, there are other programs that conduct continuing education for nurses. In fact, some of these providers are non-nursing. However, the idea of positioning the SSU program to "compete" has not been a consideration. On the other hand, it will become clearer that the competitive perspective forces the staff at SSU to identify the program's strong points and to consider ways of exploiting these features.*

The program analysis, the consultant advocated, will direct attention to other pertinent factors in the environment that might influence the continuing nursing education program at SSU. For example, the threat of new providers, the impregnable reputation of certain programs, limited access to buyers, and potential substitutes for the services of the program will be among the factors considered.

The consultant mentioned the bargaining power of buyers and the influence of this power on a business or continuing education program. Buyers' bargaining power increases if there are relatively few costs involved in switching from one provider to another—the switching allows them to move to low-priced providers. On the other hand, the power of the buyers will decrease if they are forced to buy the services from a particular provider. Thus, the availability of continuing nursing education providers and the types of offerings influence the amount of power the buyers have.

*The SSU staff must determine the "buying power" of its target groups. This information is essential to the development of a master strategy for the continuing nursing education program.*

Another factor pointed out by the consultant is the influence of "suppliers." In many businesses, suppliers can exert power over the competing firms. Although it may not appear that suppliers exert a significant amount of power on continuing nursing education, "suppliers" (those persons hired to teach or conduct an offering) do have some power.

*SSU's continuing nursing education program will review its ability to recruit and to retain faculty or consultants in an effort to explore the influence of "suppliers." These activities will be influenced to a great extent by the expected fees or salary and the fiscal constraints of the program.*

### Step 2 Determine Existing Problems

The second step of the strategy formulation process is to *determine existing problems.* In order to project the consequences of a current strategy, the consultant advised an examination of external variables, e.g., the economic outlook, the shape of future technology, and competitors' actions. In brief, this second step involves establishing premises about the environment on which an analysis of the business operations can be based.

The consultant pointed out that data from the "industry analysis" helps the manager examine the relationships between the company and the environment in which the company is located.

> *The SSU staff will discuss some of the significant trends, threats, opportunities, and problems that can influence the continuing nursing education program. These significant factors will be addressed from a national, regional, and local perspective.*

Significant factors might include:

> *Trends in Continuing Nursing Education.* Increased commercial continuing education; rapid technological change; growth of private and non-nursing providers; mandatory continuing education; nurse shortages; increased productivity expectations; decreased federal funding; advanced educational strategies.
>
> *Threats to Providers.* Monetary cuts; false advertising; time; quality of programs; low priority status of program in nursing education; disproportionate funding within the nursing education program; growth of private and non-nursing providers.
>
> *Opportunities for Providers.* Collaboration; development of different teaching strategies; networking; outreach activities; new markets, e.g., advanced practitioners, post master's and doctoral buyers.
>
> *Problems.* Inflation; competence; professionalism; territorial competition; value conflicts; lack of buyer commitment; insufficient staff and funds; poor record keeping; lack of recognition of importance of continuing education; advertising (coverage, time, cost); nurse shortages.

### Step 3 Discover Reasons for the Problems

The broad perspective from the identification of the above significant factors will help the SSU staff develop a profile of its program and *discover core elements of problems* specific to SSU. The consultant pointed out that the basic difficulty in this third step of the process may take many forms.

> *The current strategy at SSU, for example, may: (1) require more resources than the program now possesses; (2) fail to use the program's distinctive competence advantageously; (3) lack sufficient competitive advantage; (4) fail to exploit opportunities and/or meet threats in the environment; or (5) may not be internally consistent.*

### Step 4 Consider Alternatives to Solve the Problems

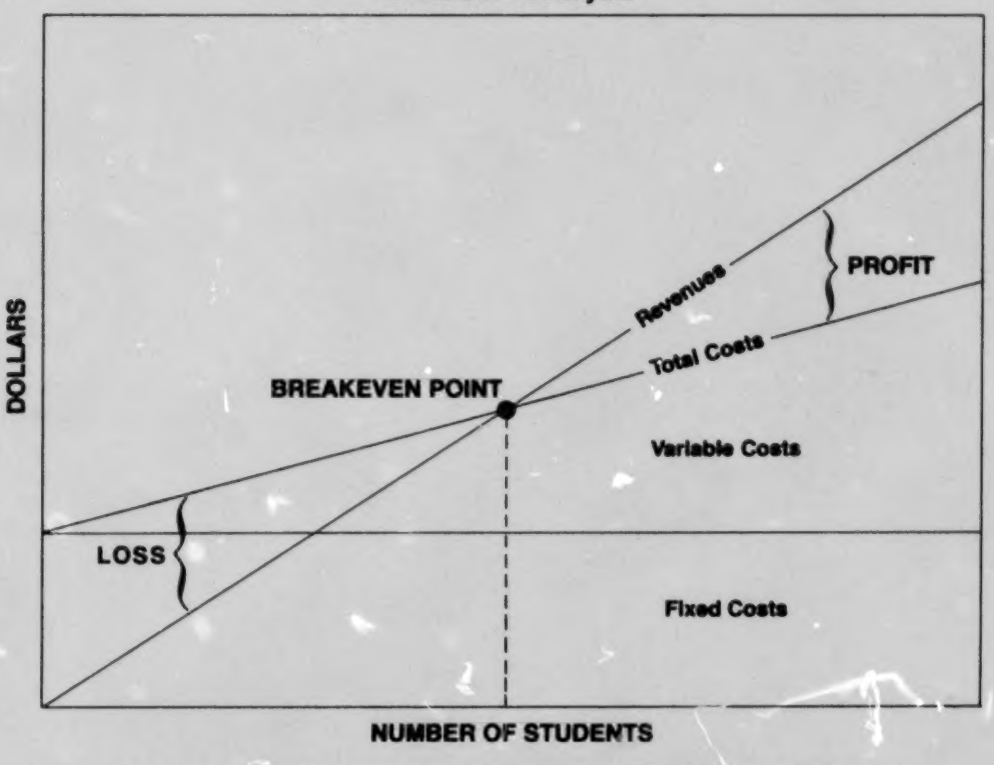
After isolating the core of the strategy problem, the consultant introduced the fourth step—*formulate alternatives.* In modern planning, the consultant advised, it is necessary to consider many alternatives that might offer some possible solution to identified problems. The consultant described three basic, or generic, strategies that are available for businesses. These are built on economic concepts and can be considered as strategy alternatives for a continuing nursing education program. For example:

*Cost Leadership.* A cost leadership strategy requires gearing all the activities of the company toward providing low cost products. Marginal customers are avoided. This strategy involves achieving low breakeven points. The low breakeven points allow lower prices; lower prices attract more customers.

Breakeven occurs when the revenues are exactly equal to costs. If the revenues are higher than costs, the business makes a profit. Conversely, the business loses money when the costs exceed the revenues. A breakeven analysis is useful in determining how much of a product to produce and sell in order to meet the costs and achieve a profit.

The consultant used the following graphic illustration to present the factors involved in determining breakeven.

**Breakeven Analysis**




Source: Handout from regional workshop in Lexington, Kentucky. (Consultants: James Lang and Jon Shepard)

Revenues equal the number of buyers multiplied by the price of the product. The total costs equal the sum of variable and fixed costs. Variable costs, the consultant explained, are those that fluctuate in proportion to the level of activity, e.g., direct labor, direct operating expenses. Fixed costs do not fluctuate with the level of activity, but are constant over a relevant range of volume. (More specific information about cost allocation is in Appendix C.) Reduction in either fixed or variable costs, therefore, lowers the breakeven point.

*Differentiation.* The differentiation strategy is based on the provision of products that are distinctly different (or perceived to be different) from those of other businesses. High quality products, advertising, and reputation are important features of this strategy. The consultant pointed out that if this strategy is applied, the manager of the company is less interested in low breakeven or low price and is more concerned about shifting the demand curve so that buyers are willing to pay more for a product.

Demand curves, the consultant warned, affect the ability of producers to increase revenues. There are two extremes, though most businesses are located somewhere between these extreme positions. In an "elastic situation" (pure competition) there are a lot of buyers and sellers. On the other hand, an "inelastic situation" (monopoly) exists when there is only one seller and a lot of buyers. A sophisticated manager, the consultant asserted, understands the degree of "elasticity" of businesses in a given area and is alert for environmental changes that can affect this "elasticity."

*Focus.* The focus strategy involves the selection of a target segment of the market to serve exclusively. The compay, according to the consultant, can achieve either cost leadership or differentiation strategies, or both, in the target segment. Other businesses that do not specialize in the target segment will be unable to match the resources of the company that does specialize.

**Step 5 Evaluate the Alternatives**

The consultant indicated few businesses have the resources to pursue multiple generic strategies successfully. The three alternatives mentioned, therefore, need careful evaluation. The alternatives should be compared in terms of: (1) their relative competitive advantages, (2) their relative effectiveness in solving the strategic problem or problems; and (3) the extent to which each corresponds to the available resources and minimizes creation of new problems. Equally important is the consistency of the strategy with management's sense of social responsibility and values. Thus, the fifth step—*evaluate alternatives*—is vital to the final step in the process—*choose a new strategy.*

**Step 6 Choose a New Strategy**

In selecting a new strategy, management isolates all factors that are of utmost importance. These factors are the determinants of decisions on policy formulation. There may

appear to be many relevant factors of significance. Management, however, must choose one or two that seem to be most important.

> *The director of the continuing nursing education will consider carefully all the alternatives that might be applied to the SSU program. The program analysis will help the staff predict variations in demand for and delivery of services. The analysis will indicate the size of the "buyer pool" for continuing nursing education and the growth stage of the program and its offerings. The development of a portfolio of offerings will help the staff identify "problem" products from those of high growth and high share. This knowledge will be important in making decisions about the master strategy for the program.*

## Summary

If directors accept the premise that continuing nursing education programs are small businesses, they must think strategically about what the programs *are* doing and what they *should be* doing. As Peter Drucker* suggests, the important questions are:

> What are the specific strengths of the program?
>
> Are these the right strengths?
>
> Are these the strengths that fit the opportunities of tomorrow, or are they the strengths that matched those of yesterday?
>
> Are the strengths positioned where opportunities no longer exist, or perhaps never did exist?
>
> What performance capacities does the program need to exploit the changes, the opportunities, the turbulences of the environment—those created by demographics, by changes in knowledge and technology, and by changes in the world economy?

This publication summarizes the six steps of a practical corporate planning method that can be applied to a continuing nursing education program. Identification and evaluation are key elements in the maintenance of quality and cost-efficient continuing nursing education programs.

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*Peter Drucker, *Managing in Turbulent Times* (Philadelphia: Harper & Row, Publishers, 1980), p. 65.

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# Appendix A*

Southern State University
College of Nursing
*Continuing Nursing Education Program*

**Expenses**
**For Year Ended June 30, 1981**

| | | |
|---|---|---|
| Personnel | | |
| Director | $30,000 | |
| Faculty A | 18,000 | |
| Faculty B | 14,000 | |
| Faculty C (50%) | 8,500 | |
| Secretary | 12,000 | |
| Sub Total | 82,500 | |
| Fringe Benefit (17%) | 14,025 | |
| | | $96,525 |
| Direct Labor | | |
| Consultants and Lecturers | 50,000 | |
| Consultant, Lecturer Travel | 5,000 | |
| Consultant, Lecturer Per Diem | 1,000 | |
| | | 56,000 |
| Operating Expenses | | |
| Instructional Supplies | 6,000 | |
| Office Supplies | 6,000 | |
| Rent | 600 | |
| Duplicating | 4,000 | |
| Advertising | 12,000 | |
| Telephone | 1,000 | |
| Postage | 2,000 | |
| Travel | 2,500 | |
| Equipment Lease | 2,400 | |
| Total Operating Expenses | | 37,500 |
| Institutional Overhead | | |
| (Total Personnel x 30%) | | |
| Total O/H Expenses | 28,957 | |
| | | 28,957 |
| | Total | $218,982 |

*Adapted from Handout prepared by John Taylor, 1982.

## Income Statement
## For Year Ended June 30, 1981

| | | | |
|---|---|---|---|
| Gross Receipts | $240,000 | | 100% |
| Less Refunds | 9,600 | $ 9,600 | 4% |
| Net Sales | 230,400 | | 96% |
| Variable Expenses | | | |
| Direct Labor | | | |
| Consultants | 50,000 | | |
| Travel | 5,000 | | |
| Per Diem (lodging, food) | 1,000 | | |
| | | 56,000 | 23% |
| Indirect (Allocated) Labor | | | |
| C.E. Director (40%) | 12,000 | | |
| C.E. Faculty A (80%) | 14,400 | | |
| C.E. Faculty B (100%) | 14,000 | | |
| C.E. Faculty C (90% of ½ time) | 7,650 | | |
| Secretary (85%) | 10,200 | | |
| Subtotal Allocated Labor | 58,250 | | |
| Fringe Benefit, 17% | 9,902 | | |
| | | 68,152 | 28% |
| Direct Operating Expenses | | | |
| Supplies | 6,000 | | |
| Rent | 600 | | |
| Advertising | 12,000 | | |
| Duplicating | 3,000 | | |
| | | 21,600 | 9% |
| Indirect (Allocated) Operating Expenses | | | |
| Standard hourly rate (2.50 x 2400 course hrs.) | 6,000 | | |
| | | 6,000 | 2.5% |
| Total Variable Expenses (Excluding Refunds) | | 151,752 | 68% |
| Fixed Costs | | | |
| Allocated Overhead (Sum of indirect labor times percent of institutional o/h rate @ 30%) | 20,445 | | |
| Unallocated Labor (Total labor minus Indirect Labor) | 28,373 | | |
| Unallocated Op. Exps. (Total Op. Exps. minus Total Direct and Indirect Op. Exps.) | 9,900 | | |
| Unallocated overhead (Total institutional o/h minus Total allocated o/h) | 8,512 | | |
| Total Fixed Costs | | 67,230 | 28% |
| Total Costs | | 218,982 | 92% |
| Surplus (Profit) | | $ 11,418 | 4% |

# Appendix B*

## ANALYSIS OF CONTINUING NURSING EDUCATION

An important first step in strategy planning is to organize information on data so that it can be assessed systematically. Consider continuing nursing education in its broadest sense. Try to think at the national and/or regional level and also within your own *served market*. Your served market is that geographic area in which you can reasonably provide services.

| | NATIONAL/REGIONAL | YOUR SERVED MARKET |
|---|---|---|
| Categories of Offerings | | |
| Types of Buyers | | |
| Market Segments | | |
| Potential Buyers | | |
| Historical Growth Pattern | | |
| Anticipated Growth -- Short-term (1-2 years): Long-term (3-10 years): | | |
| Factors That May Affect Growth | | |
| Methods of Selling and Promoting | | |
| Pricing Policies and Tactics | | |
| Innovations | | |
| Characteristics of Most Successful Providers | | |
| Characteristics of Least Successful Providers | | |
| Rate of Entry of New Providers | | |
| Percent of Providers Leaving | | |
| Suppliers -- Availability of: Labor Funding Facilities | | |
| Substitutes for Programs | | |
| Complementary Products and Services | | |

*Adapted from Handout prepared by James Lang and Jon Shepard, 1981.

## SELF-AUDIT FOR PROGRAM DECISIONS

**Mission:**

**Objectives:**

**Organizational Strengths:**

**Organizational Weaknesses:**

Correctable:

Non-Correctable:

**Organizational Resources:**

## ANALYSIS OF OTHER CONTINUING NURSING EDUCATION PROVIDERS

Systematically analyze other providers of continuing nursing education in your served area. Knowing more about them will help you in emphasizing the strengths of your program.

| PROVIDER | FUTURE GOALS | ASSUMPTIONS | CAPABILITIES | CURRENT STRATEGY | PROVIDER'S RESPONSE PROFILE |
|---|---|---|---|---|---|
| A. | | | | | |
| B. | | | | | |
| C. | | | | | |
| D. | | | | | |
| E. | | | | | |

## ANALYSIS OF ENVIRONMENTAL AND INDUSTRY FACTORS

Describe and assess the influence of environmental factors and industry forces on continuing nursing education programs in your area.

| ASSESSMENT OF ENVIRONMENTAL FACTORS | |
|---|---|
| Served markets dominated by a few providers or is there balanced competition? | |
| Bases of competition (price, quality, services, etc.) | |
| Growth rate | |
| Fixed costs high? | |
| Can buyers easily switch providers? | |
| Competitors diverse or similar in goals, strategies | |
| Exit barriers? | |

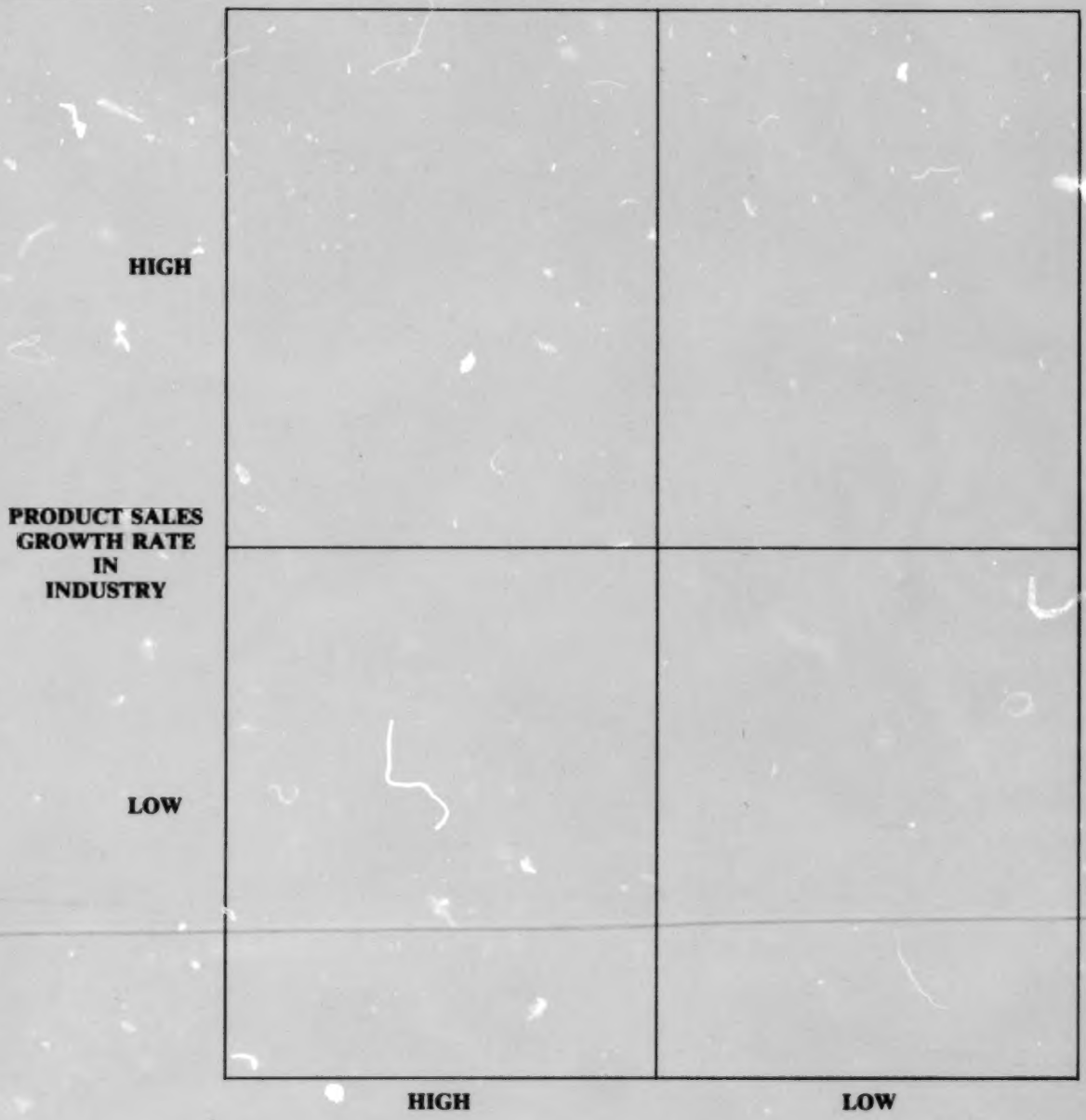
| ASSESSMENT OF INDUSTRY FORCES | |
|---|---|
| Threats of substitutes for continuing nursing education? | |
| Threats of new entrants? | |
| Bargaining Power of Buyers<br>Sources of power --<br>Concentrated purchases?<br>Standard products?<br>Low switching costs?<br>Buyers have full information?<br>Can buyers provide own continuing education?<br>Amount of power<br>Is power growing? | |
| Bargaining Power of Suppliers<br>Sources of power --<br>Unique skills?<br>Other employment opportunities (labor)?<br>Other application of funds?<br>Amount of power<br>Is power growing? | |

Based on your assessment of environmental factors and industry forces and the information gleaned from your strategic planning document and analyses of your continuing education program and offerings, develop an executive summary of the highlights.

| EXECUTIVE SUMMARY | |
|---|---|
| Most significant trends in continuing nursing education | |
| Most significant threats to existing providers | |
| Most significant opportunities for existing providers | |
| Most significant problems in continuing nursing education | |

## GROWTH RATE — MARKET SHARE MATRIX

Using circled letters (ⓐ, ⓑ, ⓒ, . . .) place each of your current programs into one of the four cells of the Growth Rate — Market Share matrix. Vary the diameter of each circle in proportion to the annual dollar revenue from each current program.



## ANALYSIS OF OFFERINGS

Based on what you have learned, you can now develop a strategy assessment of your program mix. This, in turn, will help you formulate an overall strategic plan.

### PRODUCT GRID ANALYSIS

First list your current offerings and proposed offerings. For each current and proposed offering, indicate its estimated growth rate, projected market power, and contribution to the Continuing Nursing Education program's annual revenue.

| | ESTIMATED GROWTH RATE | PROJECTED MARKET POWER | CONTRIBUTION TO ANNUAL REVENUE |
|---|---|---|---|
| **Current Programs:** | | | |
| A. | | | |
| B. | | | |
| C. | | | |
| D. | | | |
| E. | | | |
| F. | | | |
| G. | | | |
| H. | | | |
| I. | | | |
| J. | | | |
| K. | | | |
| L. | | | |
| M. | | | |
| N. | | | |
| **Proposed Programs:** | | | |
| A. | | | |
| B. | | | |
| C. | | | |
| D. | | | |
| E. | | | |
| F. | | | |
| G. | | | |

## STRATEGIC PLANNING DOCUMENT

Complete the Planning Assumptions and then draft a skeletal strategic plan that can be used to provide direction for your program. This plan should be based upon all of the information and ideas suggested by the Self-Audit. Although it may be necessary to obtain details and/or modify the strategic plan later, it is important that you be as *specific* and *concrete* as possible.

### Planning Assumptions

Objectives Not Being Met:

Revised Objectives, If Any:

Most Immediate Problems:

Key Industry Threats:

Key Industry Opportunities:

**Strategic Posture** (Circle One): Positioning (Defensive) Influencing Balance (Offensive) Exploiting Change (Jumping the Trend)
**General Strategy** (Circle One): Cost Leadership Differentiation Focus

| ACTION | GOAL OF ACTION | BY WHEN? | RESOURCES REQUIRED | FIT WITH MARKET PLAN | ORGANIZATIONAL CHANGES | BUDGET CHANGES | PROCEDURAL CHANGES | OBSTACLES AND COMPETITOR RESPONSES | PRIORITY |
|---|---|---|---|---|---|---|---|---|---|
| #1 | | | | | | | | | |
| #2 | | | | | | | | | |
| #3 | | | | | | | | | |
| #4 | | | | | | | | | |

# Appendix C*

## Cost Allocation

Costs are allocated under the following general headings in continuing nursing education:

**VARIABLE COSTS**

Those costs which fluctuate in proportion to the level of program activity.

*Types of Variable Costs*

Direct Labor—Fees, honoraria, department salary, travel, etc. directly attributable to offerings.

*Indirect (Allocated) Labor—That proportion of the department's personnel expense attributable to offering production, but not to a specific offering.

Direct Operating Expenses—Supplies, advertising, duplicating, etc., directly attributable to offerings.

*Indirect (Allocated) Operating Expenses—That proportion of the department's operating expenses attributable to offerings production, but not to a specific course offering.

**FIXED COSTS**

Those costs which do not fluctuate with the level of activity but are constant over a relevant range of volume.

*Types of Fixed Costs*

*Allocated Overhead—That proportion of institutional overhead expense directly attributable to offering production.

*Unallocated Labor—Total department personnel expense less direct labor and indirect allocated labor.

*Unallocated Operating Expenses—Total operating expenses less the sum of direct and indirect operating expenses.

*Unallocated Overhead—Total institutional overhead less allocated overhead.

*Allocated by application of various standard rates per offering hour when planning specific programs. When activity creates an increase in variable costs, there is a reduction in the relative fixed costs until the workload requires additional personnel.

An example of cost allocation for an offering planned at Southern State University follows.

---

*Handout prepared by John Taylor, 1982.

The director estimated the following costs* for an offering of 12 contact hours on burnout:

| | |
|---|---|
| Workbooks | $ 50.00 |
| Travel expense for guest lecturer/consultant | 232.00 |
| Honorarium for guest lecturer | 600.00 |
| Standard allocation rate for unallocated expenses ($19.49 per contact hour) | 233.88 |
| Room rental for offering | 50.00 |
| Lodging for guest lecturer | 56.00 |
| Faculty A, moderator for offering (18,000/2,080 x 16) | 139.00 |
| Duplicating | 34.00 |
| Per diem (guest lecturer) | 55.00 |
| Standard rate for indirect (allocated) labor ($28.39 per contact hour) | 340.68 |
| Postage | 100.00 |
| Advertising | 160.00 |
| Telephone | 12.00 |
| Standard allocation rate for indirect (allocated) operating expenses ($2.50 per contact hour) | 30.00 |
| Food, coke, coffee | 40.00 |
| Insitutional Overhead (30% of indirect [allocated] labor) | 102.00 |
| Total | $2234.76 |

*The variable and fixed costs are shown on the worksheet.

## Program Planning Worksheet

PROGRAM TITLE Burnout

DATE _____ CONTACT HOURS 12 CEU _____

| Receipts | $ Budgeted | % | $ Actual | % |
|---|---|---|---|---|
| Gross Receipts | 2750.00 | 100 | | |
| Less Refunds | 110.00 | 4 | | |
| Net Receipts | 2640.00 | 96 | | |

| Variable Costs | $ Budgeted | % | $ Actual | % |
|---|---|---|---|---|
| Direct Labor | | | | |
| Consultant Travel | 232.00 | | | |
| Honorarium | 600.00 | | | |
| Consultant Lodging | 56.00 | | | |
| Faculty A | 139.00 | | | |
| Consultant Per Diem | 55.00 | | | |
| Indirect (Allocated) Labor | | | | |
| (28.39 x 12) | 340.00 | | | |
| Direct Operating Expenses | | | | |
| Workbooks | 50.00 | | | |
| Room rental | 50.00 | | | |
| Duplicating | 34.00 | | | |
| Postage | 100.00 | | | |
| Advertising | 160.00 | | | |
| Telephone | 12.00 | | | |
| Food | 40.00 | | | |
| Indirect (Allocated) Operating Expenses | | | | |
| (2.50 x 12) | 30.00 | | | |
| Subtotal | 1899.00 | 69 | | |

| Fixed Costs | $ Budgeted | % | $ Actual | % |
|---|---|---|---|---|
| Allocated Overhead (Institutional) | | | | |
| (340.68 x 30%) | 102.00 | | | |
| Unallocated Expenses | | | | |
| (19.49 x 12) | 234.00 | 12 | | |
| Subtotal | 336.00 | 13 | | |

| Summary | $ Budgeted | % | $ Actual | % |
|---|---|---|---|---|
| Total Expenses (Fixed + Variable) | 2235.00 | 81 | | |
| Surplus / Profit @ _____% | 224.00 | 8 | | |
| Total Offering Cost | 2459.00 | 89 | | |

Estimated Minimum Attendance 45 Actual Attendance _____

**Breakeven Fee:** Total budgeted expenses divided by estimated minimum attendance $50

**Optimum Fee:** Total budgeted offering costs divided by estimated minimum attendance $55

**Profit/Loss:** Net receipts less total expenses, budgeted $405 actual _____

**Cost Per Contact Hour:** Budgeted $186 actual _____

**Decision To Go:** If enrollments at breakeven fee will cover all variable costs and any portion of fixed costs—go. If not, abort.

The *indirect operating expenses* of the Southern State University continuing nursing education program were computed as follows:

| | | |
|---|---|---|
| The total operating (direct and indirect allocated) expenses related to offerings | = | $27,600 |
| Direct operating expenses | = | 21,000 |
| Indirect operating expenses | = | 6,000 |

The director computed the *standard rate per offering* by dividing the indirect operating expenses by the total contact hours offered during the year.

Therefore at SSU, the standard rate per offering hour $= \frac{\$6,000}{2,400} = 2.50$

The director determined the *allocation of indirect labor* by establishing the percentages of time each person in the continuing nursing education program spends on offering production. For example:

| | |
|---|---|
| Director | 40% |
| Faculty A | 80% |
| Faculty B | 100% |
| Faculty C | 90% |
| Secretary | 85% |

Each person's salary was multiplied by this percentage. For example:

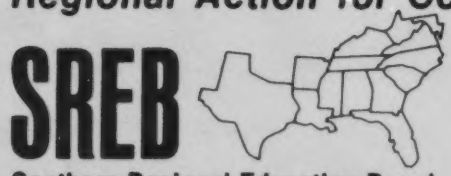
| | | |
|---|---|---|
| Director | $30,000 x 40 = | 12,000 |
| Faculty A | 18,000 x 80 = | 14,400 |
| Faculty B | 14,000 x 100 = | 14,000 |
| Faculty C | 8,500 x 90 = | 7,650 |
| Secretary | 12,000 x 85 = | 10,200 |
| | | 58,250 |
| Fringe Benefit (17%) | = | 9,902 |
| Total Indirect Allocated Labor | = | 68,152 |

When costing out specific offerings, the director divided the total indirect allocated labor by the total contact hours offered during the year. At SSU,

$\frac{68,152}{2,400} = 28.39$

Thus, the standard rate of indirect labor per contact hour is $28.39.

***Regional Action for Continuing Education in Nursing Project***




**Southern Regional Education Board**
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# GERONTOLOGICAL NURSING: IMPLICATIONS FOR CONTINUING EDUCATION

January 1982

*During the fall 1981 Council meeting Lois Knowles*, gerontological nurse specialist (University of Fla.), met with directors of continuing education programs to discuss the present status of nursing care of the aged population and to review the continuing education needs of nurse faculty. A synopsis of the paper Dr. Knowles presented follows. The project staff believes this paper will be helpful in planning regional or subregional offerings for faculty.*

Since 1966, when the American Nurses' Association declared gerontological nursing a specialty, faculties in schools of nursing have made sporadic attempts to prepare themselves to the magnitude predicted by the demographers. Approximately 12 percent of the total population today consists of the over-65 age group. By 2030 the over-65 age group will contain a predicted 50 million people. Although the majority of the aged live active lives in their own households, 47 percent are limited in activity due to chronic conditions.

Long-term health care for the aged must be provided within the context of family, community, and cultural life patterns. The complex interaction between health factors and social factors complicates the provision of long-term health care. Consequently, an inter-disciplinary and inter-agency approach is required for effective and efficient delivery of services. Professional nurses, as one of the provider groups, must be knowledgeable about the diverse needs of the aged population. Educational programs, therefore, must provide opportunities for nurses to acquire, maintain, and expand their knowledge base and skills in this specialized area.

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*Dr. Knowles is professor of Nursing at the University of Florida and a Fellow of the American Academy of Nursing. The paper presented to the Continuing Education Group will be published shortly by the Southern Council on Collegiate Education for Nursing.

Dr. Knowles pointed out that concerns about the preparation of nurses to care for the aged population have been addressed by several authors. For example, she mentioned:

> Undergraduate nursing programs place little, if any, emphasis on the care of the elderly. There are a lack of role models and insufficient numbers of qualified instructors to teach gerontological nursing courses (Burnside, 1980).
>
> Less than 20 percent of the nursing schools in a study sponsored by the American Nurses' Association (ANA) offer a course concerned with gerontological nursing. Aspects of gerontological nursing are integrated in courses, e.g., medical-surgical and psychiatric-mental health nursing (Sullivan, 1978). There is some controversy regarding the integrated versus discrete gerontological nursing courses. Some educators advocate separate courses for gerontological nursing (Etten, 1979).
>
> Of the 138 faculty respondents in the ANA study, the majority reported self study (94 percent) and continuing education (99 percent) as the methods used to acquire gerontological nursing knowledge. Most (42 percent) had 1-2 years experience in the formal teaching of gerontological nursing (Sullivan, 1978).
>
> Although viewed as temporary, stop-gap measures, well planned continuing education offerings help professional nurses, prepared at baccalaureate and master's levels, keep informed of current knowledge and skills relative to the aged population (Shields, 1978).

The facts, according to Dr. Knowles, demonstrate the need to include more gerontological content in the nursing curriculum at all levels. Improved nursing service to the aged population depends upon a sound knowledge base. Coursework alone on concepts about aging is insufficient; actual practice under the direction of prepared clinicians is essential.

Creative teaching methods and selected learning experiences can reverse some of the negative attitudes faculty and students have about caring for the elderly. These attitudes are inevitable in a specialty where negative societal attitudes prevail. Dr. Knowles suggested a scientific and humanistic approach to dissolve the block of helpless feelings experienced by many nurses. This approach includes, but is not limited to, the following:

- Formulation of specific nursing care objectives
- Planned initial experiences with persons able to communicate verbally and realistically
- Provision of opportunities for students and faculty to discuss feelings and attitudes

- Selection of clinical settings where nursing staff cooperates with students and faculty
- Provision of appropriate role models
- Demonstration of the relatedness of theory and practice

Consistent administrative support of qualified faculty is essential in the successful implementation of this approach. It is also an important factor in minimizing the professional loneliness of persons who elect to work with the elderly. The gerontological specialty in nursing, asserts Dr. Knowles, must be accorded recognition and other professional confirmation. This specialty area is different. Persons, therefore, responsible for the care of or the preparation of others to care for the aged need a knowledge base specific to gerontological nursing. Faculty teaching assignments and nursing curricula should reflect this awareness.

The development of gerontological nursing standards and an outline for continuing education courses by the American Nurses' Association (1974, 1976) helped to establish parameters for the knowledge base of gerontological nursing. Two journals, Journal of Gerontological Nursing and Geriatric Nursing: American Journal of Care for the Aging, and approximately 20 gerontological textbooks, published during the past three years, are primary sources of the present knowledge base. A few nurse researchers have contributed to the identification of gerontological nursing knowledge base. There is, however, a paucity of gerontological nursing research. Dr. Knowles believes research related to gerontological nursing must be increased and improved. Studies can document the healthful coping patterns of the elderly and be used to plan and make decisions regarding the delivery of health services to the aged population.

Gerontological nurse specialists, Dr. Knowles asserts, can influence positive changes in several areas that currently inhibit the advancement of the specialty. Specifically, she refers to improvements in the attitudes of faculty and students toward the specialty area and in the delivery of nursing care in clinical settings.

Until gerontological nursing content is increased in undergraduate and graduate nursing programs, faculty and practicing nurses will need to augment their knowledge and skills via continuing education. Well-planned continuing education offerings are imperative for professionals who must keep abreast of current knowledge in the gerontological specialty area. Regional or subregional offerings designed specifically for nurse educators may be cost efficient means by which persons responsible for gerontological content in the nursing curriculum can enrich their skills, establish networks with colleagues, and collaborate in research endeavors.

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This is a publication of the Regional Action For Continuing Education in Nursing Project, a three-year grant (DIONU24062) funded by the Division of Nursing, Department of Health and Human Services and administered by the Southern Regional Education Board.

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HE

# A CONSORTIUM APPROACH TO STATEWIDE ASSESSMENT OF CONTINUING EDUCATION NEEDS

*Lynda Nauright* asserts the consortium approach to assessment of continuing education needs of nurses on a statewide basis has several advantages: It is cost-effective for the organizations involved and reduces the number of times a nurse is asked to respond to similar questionnaires. This approach was used to assess the continuing education needs of nurses in the state of Georgia. We believe the description that follows will be of value to others.*

The consortium, organized by Dr. Nauright, included representatives from Emory University's Nell Hodgson Woodruff School of Nursing, the Georgia Nurses' Association, Georgia Hospital Association, and the Georgia Center for Continuing Education. This group helped to design a survey for the assessment of the continuing education needs of nurses. The survey, modeled after two previous needs assessment surveys of Georgia nurses (a 1978 survey by Emory University and a 1972 survey by the Medical College of Georgia), was conducted in fall 1980. It was pilot-tested by 22 representatives of the Continuing Education Community Advisory Council for Nell Hodgson Woodruff School of Nursing.

The population to be surveyed was divided among the consortium participants. The representatives surveyed the population most closely related to their organizations. Each was responsible for duplicating the questionnaire, writing an appropriate cover letter, and distributing the questionnaire and cover letters to the assigned populations. Table 1 identifies the populations assigned to each member organization of the consortium.

The questionnaires were distributed to 2,861 registered nurses. When possible, the questionnaires were mailed to representatives of selected area agencies or nursing specialty groups. These representatives distributed the questionnaires to registered nurses within their "cluster," collected the questionnaires in sealed envelopes, and returned them to Emory. In a few cases cluster sampling was not possible. The questionnaires were mailed and returned individually.

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**This paper was prepared by Dr. Nauright, Associate Professor and Director of the Non-Degree Program at Nell Hodgson Woodruff School of Nursing (Emory University). She serves on the advisory committee for the Regional Action for Continuing Education in Nursing Project and is a member of the Continuing Education Committee of the Southern Council on Collegiate Education for Nursing.*

*The activities described in this paper were funded, in part, by a grant from the Division of Nursing, Department of Health and Human Services (PHS #DIONU24070).*

The distribution, collection, and analysis of data were coordinated at Emory University. Results of the analysis included a report of the number and frequency of responses to each item on the questionnaire and a graphic interpretation of frequency data in the form of histograms. Also included were two-way cross tabulations for particular items.

TABLE 1

QUESTIONNAIRE DISTRIBUTION BY AGENCY

| AGENCY | NUMBER |
|---|---|
| Nell Hodgson Woodruff School of Nursing | |
| Nurse Practitioners | 435 |
| Psychiatric Mental Health Nurses | 85 |
| Nurse Faculty | 50 |
| Temporary Staffing Agency Nurses | 150 |
| Occupational Health Nurses | 354 |
| Georgia Center for Continuing Education | |
| Public Health Nurses | 80 |
| Extended Care Facility Nurses | 115 |
| Home Health Agency Nurses | 101 |
| Nurse Faculty | 102 |
| Georgia Hospital Association | |
| Hospital Nurses | 708 |
| Nursing Service Administrators | 131 |
| Inservice Educators | 72 |
| Georgia Nurses' Association | |
| Members from Districts 2, 6, and 7 | 478 |
| TOTAL | 2,861 |

Of the 2,861 questionnaires distributed, 1,250 were returned in time to be used in the initial tabulation. The questionnaires were coded so that data from a particular group could be analyzed separately. Results of the survey, compiled by a graduate research assistant, included: an overall summary of the data for the total population; demographic characteristics; interest in continuing education; preferences for scheduling, format, and content; opinions concerning career counseling services. Responses to these areas were compared for nurses working in various employment settings (general hospitals, community health agencies, schools of nursing, occupational health, psychiatric/mental health care facilities and gerontological/geriatric care facilities), and for nurses holding selected positions (nurse practitioners, clinical nurse specialists, and staff development directors) regardless of employment setting.

The decentralized collection technique and the use of cover letters by the organization most closely associated with the target population contributed significantly to the 44 percent response rate. A 56-page report was prepared and shared with members of the consortium. Each organization has used the information to plan offerings consistent with the needs of its constituent group, thus eliminating unnecessary competition and duplication. All members of the consortium, as well as other continuing education providers in the Georgia University system, are represented on the Continuing Education Community Advisory Council for the School of Nursing. This group meets twice per year to discuss plans for continuing education offerings in Georgia.

The following highlights of the responses illustrate the rich source of data available for planning continuing education offerings for nurses in Georgia:

- Well over three-quarters (88 percent) are employed full time, predominantly in hospitals (46 percent) or community health agencies (12 percent), as staff nurses (28 percent).

- A majority (55 percent) received their basic education in a diploma program; 23 percent attended a baccalaureate program.

- More than one-third (45 percent) hold either a baccalaureate or master's degree presently, but the percentages vary widely among respondent groups--from 27 percent for industrial nurses to 96 percent for faculty in schools of nursing.

- The reported attendance at three or more programs within the past two years (73 percent) attests to the extensive interest among Georgia nurses in continuing education.

- Location and expense were the greatest barriers to attending continuing education offerings, e.g., 66 percent reported inconvenient location; 65 percent reported expense.

- A large majority (70 percent) indicated their employers will pay "some" or "all" of the fees. (Psychiatric nurses received the least support; industrial nurses received the most support from employers.)

- Georgia nurses prefer Thursday/Friday conferences with a participative format. (The nurses expressed little interest in two-way telephone programs, visiting mobile units, and educational television.)

- The highest levels of need in clinical areas were reported for family-community health programs, oncology, critical care, cardiovascular programs, and gerontological care.

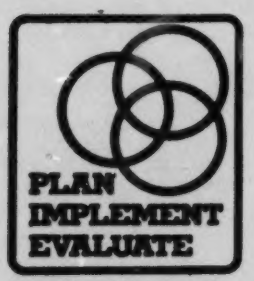
*A publication of the Regional Action for Continuing Education in Nursing Project, a three-year grant funded by the Division of Nursing (PHS #DIONU 24062) and administered by the Southern Regional Education Board.*

# REGIONAL ACTION FOR CONTINUING EDUCATION IN NURSING: AN HISTORICAL SUMMARY

During the past 10 years the Southern Council for Collegiate Education in Nursing and The Southern Regional Education Board have supported efforts to strengthen continuing education programs for nurses. The technological advances of modern society challenge professional nurses and nurse educators who are responsible for the continuing learning opportunities of practicing nurses. The current project, Regional Action for Continuing Education in Nursing, is an outgrowth of the concerns of deans and continuing education directors of nursing programs in Southern colleges and universities. This summary highlights some of the events that have influenced regional developments in continuing education. Particular attention is directed to: the formation of a regional group; the development of communication networks; the adoption of resolutions; the extension of Council membership to continuing education directors; the promotion of professional development of continuing education directors and staff; the appointment of a continuing education committee; and the development of this regional project.

## •Formation of the Regional Continuing Education Group

Following a survey of collegiate nursing programs in SREB states in 1969, the steering committee of the Council on Collegiate Education for Nursing invited representatives from 12 collegiate nursing programs to consider the formation of a regional continuing education group. This group held its first meeting in early fall 1969. Its purpose was to expand and improve continuing education programs for nurses, expecially those sponsored by colleges and universities. The group met semi-annually during 1969-1971. Discussions centered on issues and concerns related to continuing education for nurses, e.g., the philosophy of continuing education, program planning and evaluation, and plans for regional activities. By its fall 1972 meeting this group had developed objectives related to five major areas:




Regional Action for Continuing Education in Nursing

1. To facilitate communication concerning trends in continuing education among members of the group, members of the Council, and other educators.

   The purpose of this improved network of communication would be to:

   (a) promote continuing education as an integral part of nursing education programs;

   (b) increase the visibility of continuing education;

(c) encourage commitment to continuing education;

(d) encourage continuing education as an integral part of statewide and regional planning for health occupations and professions.

2. To promote interdisciplinary continuing education activities.

3. To promote the professional development of nurse faculty members who are responsible for or who teach in collegiate continuing education programs.

4. To promote faculty development for educators in all types of nursing education programs.

5. To recommend and help implement regional activities in priority areas of continuing education for nurses.

## • Development of Communication Networks

The continuing education group recognized the importance of direct communication with the Council on Collegiate Education in Nursing. Therefore, in 1972, the group asked the steering committee of the Council to allot a substantial part of the spring 1973 meeting for a discussion of issues and trends in continuing education. Attention was directed to concerns specific to continuing education for nursing during the fall 1972 and the 1973 meetings of the Council. The continuing education group was invited to the Spring 1973 meeting. This was the first time the continuing education directors attended a Council meeting; only deans and directors of degree programs attended the Council meeting.

Since the consensus of the deans and directors at the spring 1973 meeting was that information about continuing education in the region should be collected, another survey was conducted to determine the number and types of nursing programs employing a nurse educator to direct continuing education. The results, reported during the fall 1973 Council meeting, indicated 34 collegiate nursing programs had a nurse educator employed in this position. (Twenty institutions had full-time continuing education directors.) A majority of the directors (56 percent) were based in institutions with baccalaureate or baccalaureate and higher degree programs. The remainder were in settings where associate (32 percent), associate and baccalaureate (3 percent), and associate, baccalaureate, and higher degree (9 percent) programs in nursing were available.



NCE: 121280

## • Adoption of Resolutions Specific to Continuing Education for Nurses

Six resolutions, prepared by representatives of the continuing education group and the Regional Planning for Nursing project director, were presented. Three of the resolutions were adopted during the final general session of the Council; the other three, following revisions, were adopted by mail vote in March 1974. These resolutions expressed the concensus of nursing educators in the South and prompted direct action in strengthening continuing education for nurses in the region. The resolutions urged statewide planning, the development of a regional project, the provision of continuing education offerings in highly specialized areas on a regional basis, and program evaluation. (A copy of the resolutions is attached.)

## • Extension of Council Membership

During the fall 1974 meeting of the Council, representatives voted to become a dues-paying body and membership was extended to continuing education directors. Prior to this action, attendance at Council meetings was restricted to deans and directors of degree programs in nursing, except for the 1973 meetings when members of the continuing education group were invited as guests. Thus, the nurse administrative head at an institution with membership on the Council can name the continuing education director as a member and submit the required membership fee.

By the spring 1975 meeting of the Council, continuing education directors in 19 nursing programs were members of the Council. Membership increased in subsequent years. The number of nursing programs paying membership fees for continuing education directors increased from 22 in 1976 to 34 in 1978. There are now (1980) 35 nursing programs that have paid membership fees for continuing education directors. (A roster of continuing education directors who are members of the Council is attached.)

Traditionally, the continuing education directors have met prior to the opening session of the Council to discuss their special concerns. The directors participate in all sessions of the Council and provide valuable input during discussions.

## • Promotion of Professional Development of Continuing Education Directors and Staff

The continuing education group gave high priority to the third objective, i.e., promoting "professional development of nurse faculty members who are responsible for or who teach in collegiate continuing education programs." To achieve this objective, several regional workshops were cosponsored by the University of Kentucky College of Nursing and the Council.

Workshop themes included:

"Conducting Continuing Education Programs for Nurses in Colleges and Universities" (September 1974)

"Perspectives of Continuing Education in the South" (September 1977)

"Cost Effectiveness and Marketing in Continuing Education for Nursing" (August 1979)

Workshop attendance and evaluations documented the interest of nurse educators and the need for additional regional workshops.

## • Appointment of a Continuing Education Committee

A six-member continuing education committee was appointed in August 1973 to serve two years in an advisory role to SREB staff and the steering committee of the Council. The consensus of the group during its first meeting in November 1973 was that:

1. Priority should be given to activities that would promote the professional development of nurse faculty members who are responsible for or who teach in collegiate continuing education programs.

2. A regional project was needed to help coordinate continuing education developments in the region; promote the sharing of ideas and valuable resources; minimize costly and unnecessary duplication of effort in various states; and provide consultation.

This committee became a standing committee of the Council in October 1977. (A roster of appointees to the committee, 1973-1980, is attached.)

## • Development of a Regional Project

The need for a regional project was identified by continuing education directors and deans of nursing programs during the fall 1973 Council meeting. It was after that meeting that the continuing education committee began what turned out to be long-range exploration with SREB staff and the steering committee of the Council of ideas for a regional project. A proposal was prepared and submitted to the Division of Nursing, Department of Health and Human Services in October 1978. It was approved in November 1979 and funded in March 1980.



NCE: 121280

The Regional Action for Continuing Education in Nursing Project is a joint undertaking of the Southern Regional Education Board and the Southern Council on Collegiate Education for Nursing. It aims to improve continuing education for nurses in 14 Southern states by providing a developmental program for continuing education directors, facilitating statewide and interinstitutional planning for continuing education, and exploring possibilities for offering continuing education in highly specialized areas on a regional basis.

## MEMBERS OF REGIONAL CONTINUING EDUCATION GROUP 1969 FALL MEETING

Flora Lee Bain, University of Southern Mississippi
●Dorothy Blume, University of Texas
Irma Bolte, University of Kentucky
Susanna Chase, University of North Carolina (Chapel Hill)
Jane Dawson, Texas Woman's University
Alda Ditchfield, Medical College of Georgia
Betty Gwaltney, Medical College of Virginia
Dorothy Hocker, University of Tennessee (Memphis)
Frances P. Koonz, University of Maryland (Baltimore)
Linda Lambert, University of Arkansas
Phyllis Loucks, University of Alabama in Birmingham
Geralean Slack, West Virginia University
Elizabeth Stobo, University of South Carolina (Columbia)

## Attendees At 1973 Spring Council Meeting

Irma Bolte, University of Kentucky
Susan Bruno, Medical College of Georgia
Tina Calendar, Northwestern State University
Dorothy Danielson, University of North Carolina (Chapel Hill)
Betty Gwaltney, Virginia Commonwealth University
Linda Lambert, University of Arkansas
Phyllis Loucks, University of Alabama in Birmingham
Jo Ann Patray, University of Florida
Geralean Slack, West Virginia University
Elizabeth Stobo, University of South Carolina (Columbia)

## CONTINUING EDUCATION COMMITTEE Appointees for 1973 - 1976

Sara Archer, Vanderbilt University
● Dorothy Blume, University of Texas
Susan Bruno, Medical College of Georgia
Mary M. Candlers, Florida Junior College (Resigned in 1974)

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● Chairman



NCE: 121280

Frances P. Koonz, University of Maryland (Baltimore)
Phyllis Loucks, University of Alabama in Birmingham
Marie Pickarski, University of Kentucky Community College System

Appointees for 1976 - 1978

Elizabeth Benjamin, University of Southern Mississippi
Irma Bolte, University of Kentucky
Susan Bruno, Medical College of Georgia
Deanne French, Texas Woman's University
• Frances P. Koonz, University of Maryland (Baltimore)
Elizabeth Stobo, University of South Carolina (Columbia)

Appointees for 1977 - 1979

Irma Bolte, University of Kentucky
Susan Bruno, Medical College of Georgia
Joyce Hoover, University of Texas (Austin)
• Frances P. Koonz, University of Maryland (Baltimore)
Gaynelle McKinney, West Virginia University

(Note: Three members of the committee appointed in 1976 resigned.)

Appointees for 1979 - 1981

Irma Bolte, University of Kentucky
Beverly Boyd, George Mason University
Jan Evers, University of Mississippi Medical Center
• Frances Koonz, University of Maryland (Baltimore)
Melody Marshall, University of South Carolina (Columbia)

# SOUTHERN COUNCIL ON COLLEGIATE EDUCATION FOR NURSING
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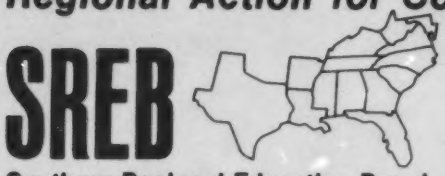
*Regional Action for Continuing Education in Nursing Project*

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# EVALUATION IN CONTINUING NURSING EDUCATION: A SUMMARY OF ONE MODEL

The evaluation of continuing nursing education programs and offerings is an essential component in the delivery of cost-efficient and quality educational services. It is a decision-making process that leads to suggestions for action to improve participant effectiveness and program efficiency. Evaluative efforts aim to provide answers to questions and to determine the extent that objectives are met.

A 1981 survey* of evaluation practices in college-based continuing nursing education programs in SREB states indicates that the majority of the respondents: are developing evaluation plans (55 percent); use the evaluation of information to plan and implement programs (99 percent); use a rating scale most frequently to assess satisfaction levels, objectives, presentations, facilities (55 percent); and perceive the primary purpose of evaluation to be for planning and improvement of program activities (67 percent). Program directors, according to 60 percent of the respondents, are responsible for the evaluation process. Most of the respondents (69 percent) reported there were no funds allocated specifically for evaluation activities.

As a result of concerns expressed by continuing nursing education program directors regarding appropriate evaluation strategies, two workshops on this topic were conducted during the 1981-82 budget period of the *Regional Action for Continuing Education in Nursing* project. These workshops were designed to help project participants develop master plans for evaluating their college-based continuing nursing education programs and offerings.

The workshops consisted of general and small group work sessions during which the project participants could discuss issues and concerns related to application of an evaluation model in their settings. To prepare for the discussion, each participant received pre-workshop readings and assignments to be completed prior to the first session.

Carolyn Waltz, Professor and Coordinator of Evaluation at the University of Maryland (Baltimore) School of Nursing, and designer of the evaluation model on which the discussions were based, was leader of both workshops. Dr. Waltz was assisted in the small group sessions by two group facilitators—Ora L. Strickland, Doctoral Program Evaluator, and Ann P. Morgan, Assistant Professor, both also of the University of Maryland (Baltimore) School of Nursing.

This report, prepared by staff of the *Regional Action for Continuing Education in Nursing* project, summarizes the model Dr. Waltz discussed and some of the principles emphasized in the group sessions. A more detailed description of the plan is presented in: Charles J. Starpoli and Carolyn F. Waltz, *Developing and Evaluating Educational Programs for Health Care Providers* (Philadelphia. F. A. Davis Company, 1978) pp. 83-108.

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*The survey was mailed to 150 project participants in the 14 SREB states: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The response rate was 40 percent.

The principles underlying the application of the proposed evaluation model to continuing nursing education programs are similar to those applied in any programmatic endeavor. The process includes five basic steps. A brief description of the steps and the key questions for each step follow.

### Step 1 Determine who will conduct the evaluation

The identification of all persons who will be available for planning and implementing the evaluation helps to determine the kind of evaluation model to be used. A descriptive statement, therefore, about the persons and resources is essential.

Key questions: Will the program director be totally responsible?

Will other persons assist the program director?

Will an outside group conduct the evaluation?

What resources exist to support the evaluation endeavor, i.e., people, money, materials?

Who will decide what changes will be made on the basis of the findings?

### Step 2 Determine the purposes of the evaluation

A statement of the rationale for conducting the evaluation helps to determine the kinds of information to be collected. An evaluation committee is helpful in delineating the information desired, the assumptions underlying the collection of the information, and the audiences for the results.

Key questions: Who decided the evaluation should be done?

Is evaluation an "inherited expectation"?

Is evaluation a requirement for funding agencies?

Is evaluation needed for program modification?

Is evaluation needed to justify the continuation of the program?

### Step 3 Describe what will be evaluated

A written description of the program that will be evaluated provides information about the characteristics of the people who will participate in the program; the facilities in which the learning experiences will occur; the program goals, objectives, and purposes; the expected behaviors of persons following the learning experiences; and relevant evaluation questions.

Key questions: What are the purposes, goals, and objectives of the program?

What are the characteristics of the learners?

What are the characteristics of the learning facilities?

What are relevant evaluation questions, i.e., evidence of cognitive, affective or psychomotor gains? evidence that objectives were met? reactions of learners to content or techniques?

### Step 4 Determine the evaluation methodology

The task in this step is to identify activities that will provide (1) answers to the questions developed by the program planners and evaluation committee, and (2) evidence regarding the successful accomplishment of program objectives. The design, criterion standards, and instrumentation are important elements. Directors of continuing nursing education programs are concerned generally with defining, describing, and determining the consequences or results of program activities. A nonexperimental design, therefore, is used more frequently in the evaluation of nursing programs. It is easier to conduct, less expensive, and requires less sophistication in research and statistics. The important determinant in the decision about evaluation methodology is the response to the question, "Who will conduct the evaluation?"

Key questions: Who is available and willing to undertake the investigation?

Do the persons available have the necessary expertise in research, evaluation, instrumentation, and content?

How much money is available for computer services, consultation, instrument development?

## Step 5 Determine when the evaluation will occur

The timing of the evaluation is crucial. Ideally, evaluation should begin at the onset of program activities. Thus, approaches that are formative and summative are helpful. (Summative evaluation is the type of evaluation used at the end of a program or activity; formative evaluation occurs during the conduct of an activity and is used to improve the process.)

Key questions: When will the findings be most beneficial?

Are the audiences for the evaluation results ready to accept those findings that may differ from what they expect?

Will the decision-makers be ready to make the necessary changes in the program?

The workshop leader and group facilitators shared some of the experiences of faculty in the School of Nursing at the University of Baltimore as they worked in the small groups with project participants. The workshop participants represented various levels of experience and backgrounds in continuing nursing education as well as in the development of program evaluation efforts. Some of the observations from these sessions follow. These observations highlight several of the critical areas that required re-emphasis in the work sessions.

**Clarification of Responsibility for Evaluation**

Lines of authority and responsibility for the evaluation of programs may be blurred. The group facilitators emphasized the importance of clarifying roles and identifying who has the decision-making power and who is responsible for what kinds of decisions. Program directors for continuing nursing education were urged to determine the "fit" of the continuing education program in the overall structure of the school of nursing (and the university or college setting) as well as to know and understand the explicit and implicit organizational norms and lines of formal and informal authority.

**Clear Statement of Purpose**

Participants were encouraged to consider the broad range of potential uses for evaluation data. Sometimes, the specific reasons for the evaluation have a limited focus. An awareness of the potential influence of program evaluation on all facets of the program and the various audiences associated with the program helps in the development of a clear statement of purpose.

**Available Resources**

The usefulness of a master plan for evaluation will be compromised by inadequate resources. A master plan, therefore, should be realistic and specific to the setting. Priority, advised the facilitators, should be given to evaluation activities necessary or deemed highly important to the organization. In some settings the program director has the sole responsibility for planning, implementing, and evaluating program activities. And often, these persons do not have adequate secretarial services, nor access to computer services and persons with expertise in research methodology and statistics. An "n of one" cannot conduct a comprehensive evaluation of the program. If more comprehensive evaluation efforts are required, the group leaders suggested that program directors negotiate for more resources by indicating what can be done realistically with the existing resources and what is possible with the allocation of additional resources.

**Adequate Program Description**

The facilitators helped the program directors examine the stated objectives and goals for their programs, since these serve as cornerstones in the development of a master strategy. The program description, they pointed out, is basic to the development of a realistic master plan. It should include pertinent inputs (consumers and personnel), operations (program procedures and techniques), and outputs (outcomes or products.). This description should be clear and easily identified.

**Identification of Audiences**

The facilitators cautioned the program directors to avoid a narrow view of the potential audiences for the evaluation data. For example, audiences within the program or the university or college setting were readily identified. There are, however, important audiences external to the program, for example, funding agencies, employers of consumers, legislators, certifying agencies. The needs of these audiences and the types of information that will be helpful to them merit careful attention. Evaluation questions can be developed to collect the data required for the various groups.

**Evaluation Questions**

A frequent question during the work sessions was "How do I know what questions are important to include in the master plan for evaluation?" Facilitators responded, "Include those questions that address concerns of importance to the program audience and program goals and objectives." Program directors were advised to:

use program goals and objectives to frame questions;

be alert to questions that arise in committee meetings;

decide what kind of information the external audiences need to make decisions about the program;

determine the kinds of information program personnel need in order to make appropriate decisions about the program.

The facilitators recommended that the evaluation questions be categorized according to inputs, operations, and outputs. Evaluation questions, according to the facilitators, should be specific enough to indicate the needed information, but not so narrow in scope that information is limited or the response can be a "yes" or "no." For example, the question, "What are the educational backgrounds and experiences of consumers of the continuing nursing education offerings?" is broad. In contrast, "What are the levels of nursing education of consumers of continuing education offerings?" is narrow in scope.

**Method**

Every effort, asserted the facilitators, should be made to build on the existing evaluation strategies rather than "re-inventing the wheel." The master plan should identify and integrate all evaluation activities. Most program directors used questionnaires to evaluate offerings. These determine consumer satisfaction with the continuing education activities. The facilitators stated there should be a direct relationship between the objectives of a continuing education offering and the manner in which it is evaluated.

Evaluation is an ongoing activity that requires time and resources. Persons responsible for the evaluation effort need to involve all program faculty and personnel when planning and implementing a master strategy. Program evaluation is an activity that is conducted best when all those involved in the implementation of the program perceive it as an integral part of their job responsibility.

The following persons participated in both regional workshop sessions and are continuing to work on the development of a master plan for their continuing nursing education programs:

*Mary Bear*, Brenau College (Gainesville, Georgia)
*Bette Bednarski*, Spalding College (Louisville, Kentucky)
*Linda Camin*, University of Texas at Arlington
*James Chatman*, Meharry College (Nashville, Tennessee)
*Ann Covello*, Daytona Beach Community College (Daytona Beach, Florida)
*Patricia Davis*, Troy State University (Montgomery, Alabama)
*Linda Holbrook Freeman*, University of Louisville (Louisville, Kentucky)
*Lee Charles Harris*, Kentucky State University (Frankfort, Kentucky)
*Elaine Humm*, Western Kentucky University (Bowling Green, Kentucky)
*Golden Kromeke*, McNeese State University (Lake Charles, Louisiana)
*Wynema McGrew*, University of Southern Mississippi (Hattiesburg, Mississippi)

Project Staff: *Audrey Spector*, Program Director
*Eula Aiken*, Project Director

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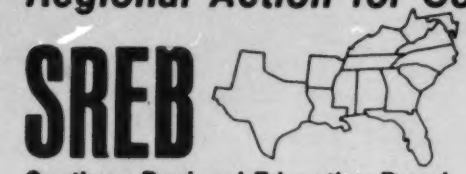
# *Regional Action for Continuing Education in Nursing Project*

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## A SUMMARY REPORT

February 1982

This report summarizes the results of two surveys conducted in the fall 1981 to elicit information about the conduct of continuing nursing education activities. One survey was mailed to the nurse administrative heads of 348 nursing education programs in collegiate settings; the other was mailed to 150 project participants. The response rate of the nurse administrative heads was 51 percent; that of project participants was 55 percent. These data provide a description of continuing nursing education programs that are located in collegiate settings in the South. The information will be useful in planning regional activities.

In this summary report the numbers in parentheses represent the percentage of responses of either the nurse administrative heads of programs currently providing continuing education for nurses or project participants.

The results show:

There are 100 nursing education programs that currently provide continuing education for nurses (56 percent of nurse administrative heads).

Continuing education was provided by 16 nursing education programs that no longer maintain the service (8 percent of nurse administrative heads).

The development of a continuing nursing education program is among the long-range plans of 24 nursing education programs (13 percent of nurse administrative heads).

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Note: The percentage of responses of the 180 nurse administrative heads by type setting: four-year college (22), university (36), junior/community college, (41); that of the 83 project participants: four-year college (25), university (47), junior/community college (28).

The earliest year reported for the establishment of a continuing nursing education program is 1959. Most programs, however, were started from 1970 to 1981 (63 percent of project participants).

The continuing education program is a separate and identifiable unit in the organizational structure of nursing education (64 percent of nurse administrative heads).

The purpose and objectives of the continuing nursing education program are explicit in the overall philosophy and objectives of the nursing education program (49 percent of nurse administrative heads).

Continuing nursing education programs have advisory committees (52 percent of project participants). Membership includes representatives from nursing education (48 percent), nursing service (43 percent), hospital administration (22 percent), general education (10 percent), nursing organizations (19 percent), consumers (27 percent), other, e.g., community health, graduate students, the Board of Nursing (12 percent).

Program directors for continuing nursing education programs are not employed full-time (55 percent of nurse administrative heads).

The percentage of time for those program directors not employed full-time varies from 85 to less than 10 percent. Most of these directors are employed 10 percent or less for continuing nursing education (47 percent of nurse administrative heads). Some directors, however, are employed for 50 or more percent of the time in continuing education (33 percent of nurse administrative heads).

The title or position of the person responsible for the administration of the continuing nursing education program varies. "Coordinator" (33 percent of nurse administrative heads) and "director" (30 percent of nurse administrative heads) are among the more frequent titles. Other titles include: associate dean, assistant dean, program head, program specialist, chairperson, instructor.

Some faculty (in addition to the program director) are employed specifically for continuing nursing education (41 percent of nurse administrative heads). The number varies from 1 to 17. Most programs, however, employ only one person (22 percent of nurse administrative heads).

A majority of the project participants (73 percent) have been employed in the continuing nursing education program from 1 to 5 years. Most (19 percent) have been employed 4 years. The reported number of years employed in a program ranges from 0 to 23.

Program directors and faculty of continuing nursing education programs have status and privileges comparable to those of program directors and faculty in undergraduate and graduate nursing programs (88 percent of nurse administrative heads) and participate on the policy-making team for nursing education (82 percent of nurse administrative heads).

The academic rank of program directors and faculty in continuing nursing education programs varies from instructor to professor. The most frequent rank reported is assistant professor (51 percent of nurse administrative heads).

Though a majority of the project participants (68 percent) hold the master's degree, some have the doctorate (24 percent).

The number of continuing education offerings per year varies from less than 5 to 16 or more. Most programs provide 16 or more offerings per year (59 percent of project participants). Less than 5 offerings per year were reported by 23 percent of the participants; 22 percent held 6 to 15 offerings per year.

Educational techniques project participants use to provide continuing education include: workshop (92 percent), self-paced instruction (17 percent), computer assisted instruction (2 percent), telelecture (4 percent), and other, e.g., preceptorship, seminar, lab practicum, lecture series (27 percent).

The educational aids used by project participants are: slides (79 percent), film (77 percent), filmstrip (66 percent), videotape (68 percent), learning modules (31 percent), case histories (59 percent), other, e.g., audiotapes, programmed instruction, handouts, simulation, role-playing (22 percent).

Primary financial support for continuing nursing education is generated by the program (52 percent of project participants). It is provided by some institutions (27 percent of project participants) or other sources (16 percent of project participants). (Other sources include state funds, capitation funds, federal grants, professional organizations, contracts with agencies.)

Financial support is included in the budget allocation for nursing education for some of the continuing nursing education programs (31 percent of nurse administrative heads). It is not, however, proportionate to the allocation for the undergraduate or graduate nursing programs (58 percent of nurse administrative heads).

The program director for continuing nursing education prepares the budget (51 percent of project participants). In a few cases it is prepared by the nurse administrative head (21 percent of the project

participants) or other persons, e.g., faculty, program sponsor, coordinator for specific offerings (22 percent of project participants).

Nurse administrative heads attribute the success of their continuing education programs to the following factors: faculty support (75 percent), institutional support (69 percent), access to consumers (77 percent), availability of resources (60 percent), program planning (70 percent), congruency of offerings with identified needs of consumers (87 percent), other, e.g., competent faculty, resourcefulness of coordinator, mandatory continuing education, previous federal grants, uniqueness of offerings (19 percent).

According to nurse administrative heads, the success of continuing nursing education is limited by: a lack of financial resources (51 percent), other providers of comparable services (31 percent), limited human resources, e.g., faculty, clerical (52 percent), other e.g., time, increased costs, territoriality of institutions (11 percent).

Responses clearly indicated that commitment to continuing nursing education--in terms of structure, philosophy, and financial support--was among one of the most important things the nurse administrator can do to promote the continuing nursing education program.

This report was prepared by the project staff of Regional Action for Continuing Education in Nursing project, a three-year grant funded by the Division of Nursing, U.S. Department of Health and Human Services and administered by the Southern Regional Education Board. (PHS DIONU24062)

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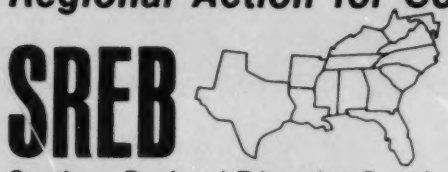


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# THE LINK BETWEEN PRODUCING/DIRECTING PLAYS AND DIRECTING CONTINUING EDUCATION PROGRAMS

The keynote speaker for the spring 1982 regional workshop on implementing cost-efficient continuing nursing education programs, Roberta Abruzzese,* advocated the use of a producer/director model by continuing nursing education directors. The role of producer is often neglected by continuing education directors. Among the many symptoms of this neglect are: unreadable audiovisuals, non-functioning slide projectors, inadequate space (either too large or too small), inappropriate breaks or no breaks, and dull speakers. Dr. Abruzzese contends that any continuing education offering that is at least one day in length has more in common with producing a play than with the typical education model used for (the design of) credit courses. Four aspects of producing a play were compared with similar aspects in producing a continuing nursing education offering. This publication summarizes Dr. Abruzzese's keynote presentation.

## The Play: Choosing the Topic for Continuing Nursing Education

Plummer, in an old book *The Business of Show Business,* says, "Many people would like to believe that selection of the right play is nothing more than a piece of pure luck, and that you never can tell what will succeed and what will fail. They regard theatrical success to be as purely accidental as a game of roulette."[1] With a few words changed, this could apply to choosing topics for continuing education offerings. Ask any continuing education director who has diligently performed a needs analysis about the success rate for choosing topics for offerings according to needs indicated in the survey. For example, something on pharmacology almost always rates high on a list of needs or interest. Yet, there are probably more undersubscribed offerings on pharmacology than on any other single topic in the United States. This causes many continuing education directors to believe that the selection of the correct topic is nothing more than a piece of luck. They can never tell what will attract a large audience and what will have to be cancelled.

Experienced directors will be the first to acknowledge that they do not know everything about choosing topics that will become successful offerings. However, some helpful rules from show business are pertinent to the selection of topics.

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**Roberta Abruzzese is the director of continuing nursing education at Adelphi University School of Nursing (New York) and chairman of the American Nurses' Association Council on Continuing Education.*

A standard dictum in show business is: "Open and close the season with a strong title, and place experimental, lesser-known titles in between."[2] Using this dictum, continuing nursing educators would have some strong standard offerings to begin each semester. For example, at Adelphi University, the semester always begins with the Nurse Refresher course and the Dietetic Assistant course. These are long-standing courses that always attract many participants. Each semester ends with State Board Review classes. Again, these are long-standing courses of high quality which attract many participants. Experimental offerings or those that may not attract many participants are placed strategically within the semester; for example, Friday evening seminars on Parenting, Anthropology and Cultural Problems of Nurses, Nutrition for Older Americans, Family Systems Theory, Research Skills for In-service Educators.

Another standard dictum in show business is: "Variety is the spice of life."[3] A season of the same kind of plays is like a diet of the same kind of food. All meat, all cake, or all vegetables becomes monotonous. So, too, does a semester of all workshops, or all conferences, or all evening offerings; or a semester of all psychosocial courses, or all acute care practice courses, or all high level educators' courses. The topics must be chosen with a good eye for the variety of formats possible. No little theatre would be successful if it offered a whole season of tragedies, or a whole season of high satire or of country comedy. So, few continuing education programs are successful if they consist of a whole semester of courses that appeal only to baccalaureate nurses, or educators, or acute care medical/surgical nurses.

Another dictum relates to timeliness: "Timeliness can supply a fitness which may not otherwise exist."[4] Some plays take on added meaning because of current social events. For example, Ibsen's plays *Hedda Gabler* and *Doll's House* take on added meaning in an age sensitized to women's struggle for more than second class citizenship. The film *Norma Rae,* with its union theme, was seen by many nursing groups as highlighting their needs to seek higher pay and better working conditions through collective bargaining activities. The play *Camelot* seemed perfect during the years of John F. Kennedy's presidency, yet would have been inappropriate during Richard Nixon's term of office.

A few years ago, continuing education directors wondered if they dared produce workshops on assertiveness training—a topic so threatening to some hospital administrators and nursing service directors that the content was disguised behind titles such as "Communication Skills for Problem-Solving" or "Stress Reduction for Greater Productivity." Today, in most locales, assertiveness training is a "ho-hum" topic which attracts many participants and disturbs few administrators.

What new topics are timely now? Continuing nursing education directors must be aware of the rising tide of sentiment in their own community indicative of a readiness for topics not timely before, for example, nursing diagnosis, woman's health care, child health assessment for school nurse practitioners, emergency management of nuclear accident victims. Timeliness supplies a fitness for choosing a continuing nursing education topic just as it does for choosing a play.

## The Actors: The Instructors

After choosing the play, the next most important task is to choose actors. The actors must be able to interpret the play to give it a meaning and urgency beyond the words on the page. Producers are looking for a combination of big name stars and little known, but highly competent, actors. Big name stars will attract a large audience initially, but attendance will be sustained only if the total play production is good. A play with a all-star cast is rarely successful; there are too many egos seeking the spotlight. The fees for big name stars are so great that ticket prices must be high—sometimes higher than ordinary playgoers are willing to pay. Similarly, in nursing, many continuing education directors have sought nationally known speakers for an offering. Some of these stars are worth the large honorariums they charge; others are not. How do producers choose actors? Do they use any guidelines that would be useful for continuing education directors? Allensworth in *The Complete Play Production Handbook* states that the four major categories considered in choosing actors are *appearance, voice, personality,* and *ability.*[5]

**Appearance.** The producer looks for a fit between a person's total bearing and manner of dress and the role to be played. Thus, a woman in hippie clothes and a wild hairdo will not be chosen for the

part of a successful business woman. Nor would a tall authoritative woman be chosen to play a helpless ingenue.

In continuing education, a mild mannered Milquetoast-looking instructor is seldom successful teaching assertiveness. A person dressed in faded blue jeans, unpolished shoes, and displaying an unkempt appearance probably will not be successful in lecturing to middle-class audiences. In general, the "producer" of continuing education offerings is looking for an appearance which will enhance the learning process and not distract from it. A successful lecturer knows how to dress so that participants will attend to the content and not the peculiarities of dress. These instructors avoid large dangling earrings that swing with every motion of the head; multiple bracelets that jangle continuously; sexy, low-cut, or tight, figure-revealing ensembles. First impressions influence whether or not people like a play or a continuing nursing education offering.

**Voice.** The producer tests the person's voice for clarity and understandability, as well as for interpretation of the role. The actor must be understandable in both pronunciation and inflection. Are words pronounced correctly and completely or are the endings of words swallowed? Are there peculiarities of speech patterns or unpleasant colloquialisms or regional accents that would be annoying to participants? Does the actor speak in a monotone, or is there proper use of vocal inflections? Allensworth says the producer is looking for "Clarity on the textual level . . .the careful enunciation of each word or syllable, the emphasis of important words or syllables through changes of pitch or inflection, and the groupings of words into phrases or clauses through the use of pauses."[6]

The continuing education producer is looking for the person who is competent in content and has good platform skills. It's amazing how many competent nurses are not good public speakers. Many teachers who are perfectly comfortable lecturing in a classroom are not able to lecture peers in a continuing education context. The best rule to follow is to hire instructors you or one of your trusted colleagues have heard present. Beware of the person who must read a speech. Very few people can ever read well. Actors spend years with voice coaches learning proper inflection, spacing, pitch, and body language to match content.

**Personality.** The producer looks for someone who projects enthusiasm, identifies with an audience, has a desire to influence others through the spoken word, and conveys a certain spark that will capture the audience's imagination and sweep them along in the story of the play. In continuing education, many directors have felt that a person competent in the topic to be presented is all that is necessary. Not enough attention is given to the role of the personality of the instructor in imparting content. Yet, we have all experienced instructors who so "turned us off" by their mannerisms or inflated ego that we could hardly hear the excellent content.

A classic study of the role of personality in relation to content is called the "Dr. Fox" effect.[7] A professional actor was given a fictitious name, Dr. Myron L. Fox, identity as an authority on the application of mathematics to human behavior, and an impressive vita. He presented a lecture entitled "Mathematical Game Theory as Applied to Physician Education," which was based on authentic material. He gave a brilliant lecture with content couched in high-sounding neologisms, statistics, and quotes from experts in the field. He interspersed the content with humor, references to unrelated topics, non sequiturs, and contradictory statements. The evaluations by the participants, who were psychologists, psychiatrists, and social workers, were overwhelmingly positive; they even said he presented his material in a well-organized fashion.

In subsequent studies,[8,9] Dr. Fox was videotaped presenting the lecture in different combinations of content and personality. The content was high, medium, and low; the presentation was seductive, ordinary, and boring. Audiences of professionals were asked to take a cognitive test on the content and to evaluate the lecturer. The scores on the cognitive tests were higher for the "low content-high seductive" lecture than for the "high content-boring" lecture! The "high seductive" presentations resulted in a higher cognitive score for the lectures of high, medium, and low content than did the "boring" lectures presented in high, medium, or low content. Other studies[10] have shown that this is not a single lecture phenomenon, but will persist for at least two sequential presentations.

The lesson for continuing educators is that an inspiring lecturer is better than a boring one. Personality does count when choosing an instructor—it is as important for instructors as it is for actors.

**Ability.** The producer looks for more than a well modulated voice and standard acting techniques. He is looking for that extra "something" that cannot be taught—the ability to interpret roles and convey characterizations in new ways. A current example of this "something" is James Earl Jones' portrayal of Othello. In the next to last scene between Othello and Desdemona, his beloved bride, Othello has permitted himself to believe that Desdemona is unfaithful and is berating her. Despairing of her ability to convince him of her innocence, she falls to her knees in terror. And then, for a few mysterious moments, Othello's anger breaks. He sees Desdemona for the helpless child she is and is overwhelmed once more by love for her. He gets down on the floor beside the quivering, cringing Desdemona and covers them both with his cloak. After a long tender pause, he says, "O Desdemona! Away! Away! Away!" as if he would have her flee from him and his terrible jealousy which will destroy them both. We have all heard those lines spoken in a dozen different ways. We have heard them as angry dismissal and as thunderous condemnation. This interpretation by James Earl Jones will stand as a classic that few actors will dare to ignore in future interpretations.

The continuing education director, too, is looking for more than ability as demonstrated by teaching experience and proper credentials of degrees and experience. We are looking for that extra "something" that will convey knowledge to adults in an interesting and fascinating way. We look for ability to add "flesh and blood" to empty theory, to relate the latest theories and techniques to current problems in practice, to assist learners to find new and different approaches in solving problems, to inspire learners to heights of creativity that they themselves did not know they possessed. We want instructors who have the ability to facilitate learning in a heterogenous group so that all are pleased with their learning at the end of the offering.

## The Play Director: The Continuing Education Director

The role of director of plays, as we know it today, was not always in existence. Today we think of the director as the person who is responsible for coordinating all aspects of production—acting, scenery, lighting, costumes, music—so that the play will make a single, unified impact on the audience.[11] The roles of producer, manager, and director are sometimes fused into one, as in many small theatres. In other instances, there may be three people to fill these roles. But it was not always so. In early Greek tragedy, it was the director of the chorus who was responsible for coordinating the play. In the Middle Ages, the director was sometimes a priest, or the head of the workman's guild, or whoever had the idea for the play. In the Eighteenth Century, the theatre became the domain of the actors. Each famous actor, based

Recently I attended an evening lecture by a noted speaker. There were approximately a hundred participants in a long narrow room, with the chairs arranged in long rows the length of the room. The speaker was using slides projected onto a screen that was very close to the projector. The image was too small to be seen by any except those in the middle of the first four rows. The microphone did not work; neither the sponsor of the lecture nor the instructor knew how to turn it on. Coffee and cookies had been ordered, but were delivered to the wrong room. In an effort to make the slides more visible, someone turned off all the lights and the audience was in total darkness. The audience began to get very restless and soon it was obvious that the speaker was having difficulty projecting her voice over the restless movement and whispering of the participants.

Finally, I asked if we could rearrange the room. It took less than 15 minutes to turn all the chairs to face one wall of the room which was designed to be used as a screen. We moved the projector an appropriate distance so that a sufficiently large image was projected, sent someone to the office to turn on the microphone switch at main control, and found a dimmer switch so that the audience was not in total darkness.

The speaker was good; the program was a success. Afterward the sponsor thanked me for coming to her rescue. I suggested that she check on these things prior to the start of a program. Her opinion was that she should be able to depend on technical services of the building; a professional's responsibility was to delegate technical tasks to others.

on his/her own style, determined what would be seen and how the production would be developed. The rehearsals were unimportant; all the other actors had only to strive for interpretations that would not detract from the star's performance. These stars would travel from city to city and perform the same roles over and over again, with no thought given to the other actors or to whether or not their performance contributed to a cohesive whole.

With a few words changed, this could be a description of some of our stars on the continuing education circuit a few years ago. No matter what the topic for some speakers, the lecture was just a variation of a standard speech. If there was a series of speakers for a one-day conference, each speaker would be given a precise topic to cover and also a description of the aspects to be covered by each of the instructors. Often on the day of the conference, the presentations sounded like there had never been any communication between the director and the presenters. The stars (lecturers) presented whatever content they wanted; the last speaker was often left with little that had not been covered.

Today, in theatre, and in continuing education, much less is left to chance. The play director is the final arbiter in any disagreement related to the cohesive production. Likewise, continuing education directors require speakers to coordinate their presentations with other speakers. The standards[12] recommended by the American Nurses' Association for the accreditation and approval of programs and offerings are of immense help in forcing speakers to specify their objectives, content, method of delivery, time frame, and evaluation component.

Another aspect of the director's role deserves greater attention—the selection and use of understudies. No major play would ever be produced without a well-planned and well-rehearsed backup for all the major actors. Many continuing nursing education programs have standard course instructors, but no provisions for substitute teachers. This can be a major problem when an instructor is suddenly too ill to teach or has a family crisis. Program directors, therefore, need an established system of substitutes.

## The Stage: The Learning Environment

The final production aspect to be considered is that of managing the stage itself. Continuing nursing education faculty have much to learn from the producer's attention to the stage. In show business, the availability of an adequate stage, appropriate lighting, acoustics, amplifiers, props, and scenery are major considerations in choosing a play. Barnum and Bailey would not attempt to produce a three-ring circus if there was space for only one ring. Nor would a good producer attempt a very expensive production if the theatre could hold only a handful of people. Stage management is seen as an integral part of the production. Lighting and amplification contribute much to the impact of the play.

No producer would consider his job completed when he chose a good play and booked good actors for all the roles. Yet, many continuing education faculty think their job is finished when they have chosen good topics and hired competent instructors.

> At a recent, very prestigious, meeting, three researchers were scheduled to present their findings. Each speaker had only 30 minutes to present the major points of her study. There were three slide projectors and three screens. The first speaker did not know which set of controls or which projector were for her slides. It took almost 10 minutes to unravel that problem. The second presenter had three colleagues with her. Since they had all participated in the research, she thought they should all have an opportunity to present. The third speaker was really in a desperate position—the other speakers had used all the time so she had 10 minutes in which to say something. What a fiasco! How easy to prevent!

There would be a lot of plays closing very fast if directors relied solely on others. Certainly, many functions can be delegated, but it is the producer/manager/director's responsibility to see that the people who have been delegated tasks do, indeed, carry them out. Curtain time is too late to check; the start of the lecture is too late to find out that all props are not in place. Yet, scarcely does a month go by in which I do not hear some horror tale about lack of attention to the "stage," the learning environment in continuing education.

Murphy's law states that "if anything can go wrong, it will." The experienced continuing education "producer" knows that Murphy was an optimist. The real truth is that something will *always* go

wrong, and that the "something" multiplies in proportion to the complexity of the format for continuing education. The only recourse is to be prepared for all exigencies and to staff accordingly.

In college classes, if an instructor is not so good for one session, or the room is cold, or the audiovisuals don't work, it doesn't matter so much. The students will be coming for the whole semester, and many courses are judged "O.K." in the long run, even though a few sessions were mediocre. Not so in continuing education. Most audiences are there for only one session, one all-day conference.

> An instructor arrived for a Saturday workshop at a strange college to find only a packet of instructions from the director of continuing education. There were 300 participants, mostly students, and a locked lecture hall. Imagine the anger of that instructor as she struggled to find appropriate authorities to open the building, turn on lights, etc. And, she had prepared a presentation for less than 50 people!

In continuing education, as in show business, reputations are made or broken on the strength of one exposure. Seldom do theatre goers return to a play that disappointed them to see if the amplification, lighting, or actors were better at another date. Seldom do unhappy continuing education participants return to other offerings if they have been needlessly annoyed by production problems that could have been avoided.

The production role of the continuing education director is a very challenging one that demands much ingenuity. From producers of plays, directors can learn many lessons that have relevance for choosing topics, selecting instructors, negotiating content presentation, and creating climates conducive to learning. Directors can improve their skills and adapt this model so that continuing nursing education productions live up to the old MGM adage: Do it right, do it big, and give it class.

## Notes

1. Gail Plummer. *The Business of Show Business.* (Westport, Connecticut: Greenwood Press, 1961), p. 6.
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3. Ibid., p. 7.
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5. Carl Allensworth. *The Complete Play Production Handbook.* (New York: Thomas Y. Crowell Company, 1973), p. 34.
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11. Allensworth, *op. cit.,* p. 37.
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# CRITICAL REVIEWS: EVALUATION IN CONTINUING NURSING EDUCATION

As continuing education directors we have much in common with producers and directors of plays. We must select continuing education offerings as carefully as the producer selects a season of plays. We must choose lecturers with as much care as the director chooses actors. We work as hard as any producer to manage the physical facilities of lighting, acoustics, stage props. We have promotion and publicity needs similar to any theatrical production. And, like all producers and directors, we eagerly devour the critics' reviews after the first production of each "play."

Our productions are not reviewed by Walter Kerr in the *New York Times* nor does Gene Shalit report that we were trite or ail right. Marion Etoile Watson doesn't shower us with praise. We do, however, have our own critics—they sometimes write volumes on our evaluation forms. They spread our reputations far and wide influencing how much money our "backers" will put up for our next venture. In the long run our critics, just like the play critics, will help make us or break us. The role of these critics and their evaluations in our continuing education programs merit attention.

Evaluation is a topic of much concern to continuing education providers and staff development educators. Just as a producer or director of plays ponders how much weight to attribute to any one critic, so continuing education directors ponder how much weight to attribute to various types of evaluation strategies. The major questions are: "What is appropriate evaluation for continuing education?" and "How can we prevent evaluation strategies from destroying the true meaning of adult learning?" Knowles says,

> Evaluation is the source of more confusion, frustration and guilt among adult educators than any other aspect of their work. And on this subject I should like to drop what to many of my colleagues will seem a bombshell: I think that evaluation has become a much-overemphasized sacred cow. Furthermore, I think that this very overemphasis has caused an underproduction of practical, feasible, and artistic evaluation in terms of program review and improvements.[1]

This statement was made in 1970 and still remains timely today. We are searching for practical, feasible methods of evaluating our programs. We want to demonstrate with hard scientific data what continuing education programs are accomplishing. There are, however, many problems connected with evaluation in the social sciences.

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*Roberta Abruzzese, director of continuing nursing education at Adelphi University School of Nursing (New York) and chairman of the American Nurses' Association Council on Continuing Education, was one of the workshop leaders for the Fourth Regional Workshop of the Regional Action for Continuing Education in Nursing project. The publication summarizes the ideas she presented during the workshop. A grant to the Southern Regional Education Board from the Division of Nursing, Department of Health and Human Services (PHS NU24062) provided the funds for the workshop and this publication.*

## Key Issues

To paraphase Knowles,[2] there are four points of difficulty in evaluating continuing education.

(1) It is difficult to prove that our programs alone produce desired changes because human behavior is entirely too complicated and the number of variables affecting it are too numerous. For example, note the state board review providers who claim that 95 percent of their participants pass state boards on the first try. How anyone in the wildest claims could allege that taking a particular provider's classes will assure passage of boards is beyond comprehension. The young nurses pass because they study and have studied, not because they take one provider's rather than another provider's course of review.

(2) Social science has not yet produced rigorous enough tools to measure adult learning and the many subtle outcomes of a comprehensive program. There are tools which measure cognitive or psychomotor outcomes at the completion of a learning experience, but there are no tools which can accurately measure the use of the knowledge six months later. An example would be a continuing education workshop on nursing diagnosis. In a simulated case or a case study, participants could be evaluated at the end of the workshop on their ability to accurately choose a nursing diagnosis. Their ability, however, to establish a similar diagnosis six months later may be more contingent on circumstances within the work setting than on knowledge gained in the workshop. No evaluation tool in common use could accurately assess what portion of the failure to make a proper diagnosis could be attributed to faulty learning and what portion could be attributed to work setting variables. In the same fashion how can we measure outcomes of learning such as motivation to pursue higher degrees, greater self-esteem, satisfaction with one's performance, etc.? Nor can anyone prove that nurses who have taken a 150-hour intensive care course are safer practitioners than nurses who learn on the job.

(3) The kind of intensive and scientific evaluation needed requires investments of time and money that many are not willing to commit when they already see education as valuable. For example, Adelphi University School of Nursing had a four-year contract to provide cancer nursing courses. There were elaborate evaluation strategies including a 50-item multiple choice pre- and post-cognitive examination, a 40-item affective test which was given pre- and post-course and had to be sent to Denver to be computer scored by the test author, and case studies which had to be presented orally and in writing. Constructing the 100-item multiple choice examinations required an inordinate amount of time to establish test blueprints and to write items at the application level rather than merely at the knowledge level. Administration of the examinations accounted for four to six hours of a 24-hour course. An examination specialist was employed quarter time to assist with the analysis of the data. The total cost was approximately $3,000 per semester. Were the results justified? The main finding was that there was an improvement of cognitive knowledge after the course. We knew that would happen. We have, therefore, decided to establish a much simpler evaluation form for future courses.

(4) Adult education is not like youth education. In a system in which learning is voluntary, the degree of persistence and the satisfaction of the learner are more important indicators of the worth of the program than are other rigid evaluation measures. In voluntary learning, the "student" has no obligation to please the teacher, no obligation to meet teacher-set objectives. The learner has only the obligation to gain the learning he or she was seeking. Learning is successful when the learner has persisted in learning what he or she needs to know at this time. The learner may have met none of the objectives of the teacher; the learner may have failed the evaluation procedure established by the teacher. Yet, if the learner's learning needs are met, the learning experience is successful—successful even though there are not many evaluation procedures which can measure this type of success.

Deets[3] says, "One's philosophy of continuing education is a determining factor in how continuing education is evaluated." If, like Malcolm Knowles, you are a proponent of andragogy, your philosophy reflects beliefs that adults are different from children in respect to their self concepts being that of autonomous learners, rather than dependent learners. Adults have life experiences, are problem-oriented, and usually come to learning experiences with a readiness to learn. They expect to be active participants in every phase of the learning process, including the evaluation.

Another philosophy of continuing education (at the opposite end of the scale) reflects beliefs in rigorous strict evaluation methodologies. These two opposite philosophical stances are similar to McGregor's[4] theory X and theory Y. In management these theories explain two extreme beliefs about workers, one negative and one positive. Whole organizations can sometimes be characterized as theory X or theory Y organizations. Translated into continuing education terminology, these theories characterize continuing education programs.

**Theory X**

1. The average human being has an inherent dislike of education and will avoid it if he can.
2. Most people must be coerced, controlled, directed, and threatened with punishment in order to get them to learn what they should in a class.

Theory X continuing educators believe that the participants are mediocre, lazy, and will not learn unless forced to. These beliefs call for a very rigid, fear-producing form of teacher-controlled evaluation.

**Theory Y**

1. The expenditure of physical and mental effort in learning is as natural as rest. The average human being does not dislike learning; rather, learning can be a source of either satisfaction or punishment depending on the learning design and circumstances.
2. External control and threats of examinations are not the only means of achieving learning. People will exercise self-control and self-direction in learning materials which help them solve problems.
3. Commitment to learning is a function of the rewards associated with the learning. The most significant of these rewards are ego satisfaction and the satisfaction of self-actualizing needs.
4. The average human being, under proper conditions, not only accepts but seeks learning.
5. The capacity to exercise a great deal of imagination, ingenuity, and creativity in the assessment, planning, and evaluation of learning is widely distributed in the population.
6. Under the conditions of most classrooms/learning situations, the intellectual potential of the average human being is only partially utilized.

Theory Y continuing education directors, then, believe that adults should participate in every phase of their learning, including the evaluation strategies. They believe that participants, like play-goers, are valid critics of continuing education programs.

## Evaluation Terminology

In order to develop a comprehensive philosophy about evaluation and continuing education, it is necessary to be familiar with the terminology of evaluation. Many authors are using the same words with different meanings. For example, "outcome" evaluation as described by one author may be the same as another author's use of the term "content" evaluation. Another author may use "process" and "outcome" evaluation as synonomous with "formative" and "summative" evaluation. Some authors insist that only "impact" evaluation is meaningful; while other authors insist that in adult learning, "process" evaluation is the only relevant measure. It is important, therefore, to identify the terms currently used in evaluation literature and place each term in its proper perspective.

**Formative/Summative/Mastery**

The first set of terms to consider is formative, summative, mastery learning. These terms were popularized by Bloom[3] in the early Seventies. Formative evaluation and summative evaluation refer to times at which evaluation data are collected. Formative refers to the ongoing collection of data during the implementation phase which allows for modification of an original plan. Summative, on the other hand, refers to evaluation procedures carried out systematically at the completion of the implementation phase.

Mastery learning is another of Bloom's terms which has special meaning for continuing educators. It refers to the desire for participants to reach a preset comprehension or criterion. Nothing less than 100 percent is acceptable. The length of time it takes for a participant to reach this goal is irrelevant; the aim is mastery according to established criteria. This evaluation standard is used for many nursing skills. Blood pressures, for example, must be taken 100 percent correctly; 80 percent correct has no meaning. So, too, for a host of basic nursing procedures.

**Norm-referenced/Criterion-referenced/Competency-based**

Mastery learning is related to three other terms often seen in evaluation literature. These are norm-referenced, criterion-referenced, and competency-based. Norm-referenced refers to how a person's performance compares to the performance of other people in a group. Criterion-referenced, on the contrary, refers to how performance compares to preset criteria. In this way it is similar to mastery learning—criteria are established before evaluation. It is of no consequence how other members of the group perform. In physical assessment skill courses, for example, participants are evaluated on how well they perform the critical elements; they are not judged in relation to who performs the best or the worst in the group.

Competency-based evaluation is related to mastery learning and to criterion-referenced evaluation in

that it compares the performance of the learner against standards which are determined as critical for performance. Dorothy del Bueno[6] has lectured and written widely about the uses of competency-based education and evaluation as it applies to staff development. She stresses evaluating in terms of critical competencies required by the position held. del Bueno recommends evaluation of skills for activities which are frequent, critical, and high risk. Only after these activities are satisfactorily performed is the new nurse evaluated on less critical, infrequent, or low risk activities.

## Evaluation Models

Two evaluation models often referred to in the literature are the Starpoli-Waltz model[7] and Stufflebeam's CIPP model.[8] The Starpoli-Waltz model, at first glance appears to be a very complex model that is difficult to understand. In reality, the model is basically concerned with *who, what, how,* and *when.* Who is going to evaluate? Who is going to be evaluated—students, clients, teachers? What is going to be evaluated—inputs, operations, outputs? How are these going to be evaluated? What are the instruments or tools for evaluation? How will they be designed? What are the criteria? When will all this evaluation take place? (Usually there are aspects of evaluation to be completed before, during, and after the implementation phase.)

Similarly, Stufflebeam's CIPP model can be analyzed in terms of its components: *context, input, process,* and *product.* Context assesses needs, problems, and opportunities that should be considered. Input considers ways of achieving alternate ends or intended means (processes and procedures). Process evaluations monitor actions and help them to stay in conformity with the intended ends. Product evaluation compares actual outcomes with intended outcomes and looks also at unintended outcomes.

Kirkpatrick[9] has a much simpler model which considers *reaction, learning, behavior, results.* He speaks of evaluating these four aspects in terms of learning. In his scheme, "reaction" has the lowest value while "results" has the highest value. In terms of frequency, "reaction" evaluation is most often performed, while "results" evaluation is least often performed. So, too, "reaction" evaluation is the easiest to perform, while "results" evaluation is the most difficult.

Meleis and Benner[10] use the terms *process* and *product* evaluation with meanings similar to formative and summative evaluation. At other times, the term "process" refers to the activities related to the implementation phase while the term "product" refers to all other aspects. These aspects are considered by some to be outcomes, impacts, outputs, or products. Benner and Benner[11] refer to *follow-through* evaluation. This is well known to staff development directors as "follow-up" of new employees.

Other terms frequently encountered in evaluation literature are: inputs, through-puts, outputs, impact, action-based, scientific, naturalistic, objective-based, goal-free, and goal attainment scaling. Often these terms and their varied definitions are jumbled in our thinking and leave most of us feeling very insecure about the adequacy of our own evaluation strategies.

The RSA model for the evaluation of continuing education provides a frame of reference for the varied evaluation terms. It is a hierarchy of evaluation for continuing education.

### RSA EVALUATION MODEL CONTINUING EDUCATION

**Process Evaluation:**
General Happiness with the Learning Experience

- Faculty
- Course objectives
- Content of course
- Teaching/learning methodologies
- Physical facilities

**Content Evaluation:**
Change in Knowledge, Affect or Skill

- Self-rating scales
- Pre-tests and post-tests
- Group work exercises
- Return demonstrations

**Outcome Evaluation:**
Change in Behavior After the Course

- Integration of new value
- Habitual use of new skill
- Creation of new product
- Institution of new process

**Impact Evaluation:**
Improvement in Health Care or Systems

- Quality of nursing care
- Functions within the institution
- Level of consumer health

**Total Program Evaluation:**
Congruence of Goals and Accomplishments

- Critique by advisory committee
- Reports to administration: cost, participants, curriculum
- Reappraisal of goals

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## Levels of Evaluation

**Process**

The basic level of evaluation is called *process* evaluation. This type of evaluation refers to general happiness with the learning experience. According to the American Nurses' Association accreditation process for continuing education, this type of evaluation must provide an opportunity for participants to evaluate faculty, course objectives, personal objectives, content, teaching/learning methodologies, and physical facilities. If the adult learner is not satisfied in these aspects, learning of content will be hampered. Although this type of evaluation has been in disfavor in recent years, it continues to be a crucial element for adults—especially the achievement of personal objectives. No matter what else has been achieved, if the learner has not met his or her personal objectives, the feeling is that the learning experience has failed.

**Content**

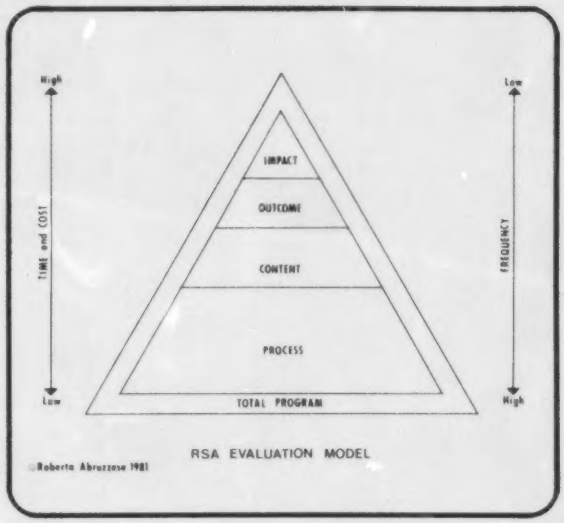
The second level of evaluation is *content* evaluation, which refers to changes in knowledge, affect, or skill immediately following a learning experience. The usual types of evaluation tools used here are self-rating scales, pre-tests and post-tests, group work exercises, and return demonstrations. Currently, pre- and post- multiple choice questions are much in vogue; there are even some state nurses' associations that will not approve continuing education offerings unless the course has a pre- and post-test. Yet most of these tests are neither valid nor reliable. To ask each learner what he or she got out of the course and intends to do with the knowledge would be a far better evaluation of the course than 10 multiple choice questions which only test immediate recall according to preset expectations of the instructor—which may or may not be meaningful to the learners.

**Outcome**

The third level of the hierarchy of evaluation is *outcome,* which is defined as change in behavior which persists after the learning experience. Most commonly these evaluation strategies take place in the months following the learning experience. Some tools used to measure this type of learning are questionnaires, observation of practice, audits, and self reports. Some examples of outcomes might be the integration of a new value, such as a change in the number of sick calls on days before and after weekends off. Another change might be the habitual use of a new skill, such as formulation of nursing diagnosis following a workshop on how to establish diagnosis. Or the learning may be related to creation of a new product, such as new staffing schedules or a new time management system. Or the learning may be reflected in the institution of a new process, such as management by objectives.

**Impact**

The fourth level is *impact* evaluation, which measures improvements in the health care of clients or in systems. Although it is very difficult to show relationships between courses and impact on clients' health, it has been done in some studies. An example is most often demonstrated in the results of outcome audit or retrospective audit. Deficiencies noted in audits are remedied by specific staff development courses. Results of the courses are measured in future audits. The level of consumer health can be related to specific courses. An example was demonstrated by impact evaluation of a perinatal nurse clinician course at Adelphi University. A study was undertaken of the mortality and morbidity of mothers and babies transferred to a tertiary care center from community hospitals before and after hiring a perinatal nurse clinician. The chart audits clearly demonstrated that not only were more mothers and babies saved but they were healthier after nurse clinicians were hired in the community hospitals.



RSA EVALUATION MODEL

There is increasing difficulty in implementing evaluation strategies from the bottom to the top of the hierarchy. Process evaluation is the simplest to perform, requires a minimum amount of time and money, and is expected of all. Content evaluation requires more skill in tool development and more time to develop and administer evaluation procedures. It

also costs a moderate amount to implement. Outcome evaluation requires greater skill in devising strategies, requires much time to perform well, and presupposes at least a beginning knowledge of how to establish baseline data and collect valid samples of behaviors before and after learning experiences. Outcome evaluation requires considerable amounts of money in terms of instructor time and salary. Impact evaluation is the most difficult, time-consuming, and costly of all evaluations. It has much more in common with research than it has with ordinary learning evaluation. To perform well requires considerable skill in measurement and evaluation—this is usually beyond the capabilities of most continuing educators. Many master's thesis or doctoral dissertations could be obtained by fulfilling the needs of continuing educators for impact evaluation.

Total program evaluation encloses the hierarchy triangle. This type of evaluation measures the congruence of goals and accomplishments. Often this is accomplished by reports to administration in terms of cost, participants, curriculum, and activities of the year. Other ways are a critique by advisory committees or a formal report in the format required for management by objectives.

The RSA model of evaluation provides a way of understanding terms used in evaluation. Just as the voices of the critics are not helpful unless we know the context in which the statements were made, so the results of continuing education evaluation are not helpful unless we know the type of evaluation utilized. Let us learn to listen to the voices of all our critics—our expert colleagues, our instructors, but most of all our participants. The voices of our critics—when used wisely—will help us live up to the old MGM formula:

Do it right, do it big, and give it class.

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**Regional Action for Continuing Education in Nursing Project**

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***December 1982***

A SUMMARY REPORT OF STATEWIDE PLANNING
FOR CONTINUING NURSING EDUCATION IN SREB STATES

Statewide planning for nursing education is not a new idea. Since the 1950s ideas for the coordination of nursing educational opportunities have been proposed. The importance of and the need for statewide planning for nursing education and more specifically continuing nursing education, increase with the projected budgetary cuts. The National Commission for the Study of Nursing and Nursing Education proposed the same quality of planning and cooperative articulation in the continued development of a professional nurse as in any aspect of the learning experience. Continuing nursing education, according to the Commission, should be an essential element on the agenda of state master planning committees (Lysaught, 1970, p. 9).

Implementation of statewide plans for continuing nursing education has been slow because of the complexity of the task. By 1978, according to Lysaught (1981, p. 176), 32 states had designated master planning committees for nursing education. Various reports attest to the efforts of some agencies and institutions to coordinate the delivery of continuing nursing education (Cooper, 1973; Carlley, 1974; Leonard, 1977; Puetz, 1978; Schweer and Puetz, 1981; Murphy, 1981).

A 1973 survey conducted by the Southern Regional Education Board (SREB), revealed that 13 of the 14 SREB states* had or were considering a statewide plan for nursing education. MacDonald (1973) reported four Southern states (Louisiana, North Carolina, Georgia, West Virginia) had completed studies to assess current and projected needs for continuing nursing education, similar studies were underway in four other states (Arkansas, Kentucky, Tennessee, Texas). However, the development and implementation of plans for continuing nursing education in this region have been slow.

In 1980, the Regional Action for Continuing Education in Nursing project staff requested information about statewide plans for continuing nursing education from project participants (who are directors of continuing nursing education programs in college and university settings), and the executive directors of the 14 state nurses' associations and 14 state boards of nursing. The target group, consisting of 167 persons, was asked to specify the status of statewide plans for continuing nursing education and to submit the name of a key person

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*The SREB states are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

to contact for more detailed information. Of the 66 respondents, 45 percent reported there was no statewide plan for continuing nursing education, 32 percent stated plans were being developed, and 23 percent reported plans were in operation. The responses of the project participants indicated their involvement in statewide plans for continuing nursing education varied from initiating meetings of key people in a state to being only the recipient of information. Most (N=30) reportedly attended meetings.

There was some discrepancy in the opinions of respondents* regarding the development, implementation, or lack of plans for continuing nursing education. Inconsistency occurred in the reactions of respondents in eight of the 13 states. For example, in one state half of the respondents (N=8) stated plans were developed (or being developed) and half claimed there was no activity. Consistency of opinion occurred in only two states where project participants (N-12) and executive directors of state nurses associations (N=2) and state boards of nursing (N=1) reported plans were either in the development or implementation phase. These contradictory reports reflect the lack of clearly identified focus of responsibility for statewide planning for continuing education.

Another questionnaire was mailed in 1981 to the key persons identified by the 1980 target group. The prime purpose of this survey was to elicit more specific information about the statewide plan for continuing nursing education in those states reported to have begun the development or implementation of activities. (Thirty of the 66 respondents identified key people to contact.) The questionnaire was mailed to 17 persons in 13 SREB states. Information was received from 10 persons (representing nine states). The results of the 1981 questionnaire indicated five states had no plans; four states were in the early stages of implementing statewide plans for nursing education and were developing plans for continuing nursing education. A brief description of these plans follows.

Maryland. The Maryland Nurses' Association, awarded a three-year federal grant in 1980 by the Division of Nursing, Department of Health and Human Services, is developing a statewide plan for coordinating existing continuing nursing education activities. Councils have been formed in the state nurses' association districts to help coordinate activities. Members of the Councils represent college, university hospital, and other health-related agency settings. At least half of the council members are continuing education providers; the remainder are consumers. It is anticipated that the system will be in place by April 1983. The Maryland Nurses' Association will be responsible for the system. Contact person: Romaine Eyler (Project Director, Statewide Continuing Education Grant, Maryland Nurses' Association, 5820 Southwestern Boulevard, Baltimore, Maryland 21227.)

Kentucky. Joint funding in 1977 by the Council on Higher Education and a W. K. Kellogg Foundation grant (obtained through the SREB Nursing Curriculum Demonstration project) enabled the Kentucky Council on Higher Education to develop a model for a statewide coordinated system of nursing education. A

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*Responses were received from 55 project participants in 13 of the 14 SREB states, executive directors of 4 state nurses' associations and 7 state boards of nursing.

19-member subcommittee on nursing education serves in an advisory capacity to Council staff. Members represent the state's eight regional university nursing programs, the University of Kentucky Community College System, the Kentucky Department of Vocational Education, Kentucky Board of Nursing, Council of Independent Kentucky Colleges and Universities, Kentucky Hospital Association, and the Kentucky Department for Human Resources' Bureau for Health Services, Continuing Education, and Nursing Service.

A task force on continuing education was formed within the Council's subcommittee on nursing education in 1978 to develop a statewide coordinated system for continuing education. The task force considered the possibilities of an interorganizational coordinating/communication model linking continuing education providers and planners at local, regional, and state levels. The time constraints of the grant prohibited extensive work in this area. The task force, however, did present a model, in cooperation with the Kentucky Nurses' Association, the Council on Higher Education, and others, for discussion at a statewide meeting in November 1980. A group of continuing education coordinators from college and university settings meet on an informal basis to coordinate the planning for continuing nursing education activities.

The Council on Higher Education views continuing nursing education as a professional responsibility. The Kentucky Nurses' Association is considered an appropriate agency to provide leadership in continuing education planning and has appointed a task force to develop a proposal for the development of a statewide system for continuing nursing education. A representative from the Council on Higher Education serves on the task force. Contact persons: Irene Hudleson (Associate Director for Nursing Education, Kentucky Council of Higher Education, West Frankford Office Complex, Frankfort, Kentucky 40601) and Irma Bolte (Assistant Dean, Continuing Education, University of Kentucky College of Nursing, Lexington, Kentucky 40502).

Arkansas. The Arkansas Department of Higher Education received funds from the W. K. Kellogg Foundation in 1977, as part of the SREB Nursing Curriculum Demonstration project activities, to develop a statewide plan for nursing education. The plan includes continuing nursing education. The Advisory Board for Planning recommended that administrators in practice and educational settings recognize and positively reinforce the nurses' commitment and responsibility to expand their knowledge base and practice skills.

Persons involved in the development of the plan included representatives from: nursing programs; State Departments of Health, Higher Education, and Vocational Education; Arkansas State Board of Nursing; Arkansas State Health Planning and Development Agency; Arkansas Medical Society; Arkansas Nurses' Association; Arkansas Student Nurses' Association; Arkansas LPN Association; and consumers. Contact person: Kathye Blagg (Director, Arkansas SREB-Kellogg Project, Arkansas Department of Higher Education, Little Rock, Arkansas 72201).

Georgia. The University System of Georgia Board of Regents and its Nursing Advisory Board to the Vice Chancellor for Health Affairs developed a statewide plan for nursing education. The planning process was financed by a grant from the W. K. Kellogg Foundation, as part of the SREB Nursing Curriculum Demonstration project activities, and the Board of Regents of the University System of Georgia. The statewide plan was developed by representatives from the Georgia Nurses' Association, the Georgia Hospital Association, Georgia Health Care

Association, Georgia League for Nursing, Home Health and Visiting Nurses Association, deans and directors of nursing education programs, and out-of-state consultants.

The statewide plan for continuing nursing education was developed during 1982. A structured communication network will be established to facilitate coordination of ideas and resources. The Academic Committee for Public Service/Continuing Education and representatives from the 33 University System Schools of Nursing, and the Georgia Nurses' Association will establish this system of cooperation. Contact person: Richard A. Hudson (Board of Regents of the University System of Georgia, Statewide Assessment of Nursing Education, University of Georgia Center for Continuing Education, Athens, Georgia 30602).

The development of statewide mechanisms to coordinate the delivery of continuing nursing education is essential for consumers and providers. Several controversial issues, however, can influence the extent to which statewide plans become more than written documents. A major issue concerns who is (or should be) responsible for continuing nursing education. Educational institutions? Service agencies? The profession? The number and diversity of providers create problems in the development and execution of any statewide coordination of efforts to eliminate unnesessary duplication of services. Thus, the efforts and recommendations of those persons who have developed, or are engaged in developing, statewide plans for continuing nursing education warrant serious study.

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Regional Action for Continuing Education in Nursing is a three-year project, funded by the Division of Nursing, Department of Health and Human Services (PHS NU 24062), and administered by the Southern Regional Education Board. (Prepared by project staff, fall 1982.)

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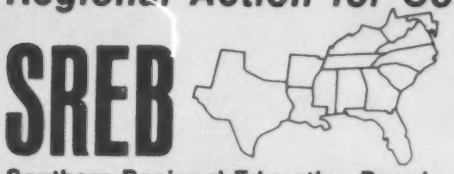


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# CONTRACTING: A MEANS OF PROVIDER SURVIVAL

*Carol Buisson, coordinator of continuing nursing education at Louisiana State University Medical Center (New Orleans), discussed the advantages and disadvantages of contracting during the Spring 1982 third regional workshop sponsored by the Regional Action for Continuing Education in Nursing project. She based her advocacy of contracting on the positive experiences in the School of Nursing. During the past two years the Louisiana State Continuing Nursing Education Program conducted 69 offerings. Fifty-two were either sole or co-sponsorships; seventeen were contracts. The contracts accounted for 24.6 percent of total staff effort and yielded 65 percent of the net profit. This statistic alone indicates the desirability of introducing contracts into sponsorship alternatives. In addition, the cost of production dropped from an average of 85 percent to 32.7 percent of income.*

*This report summarizes the highlights of Carol Buisson's presentation.*

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The effects of inflation, recession, the nurse shortage, and austerity programs in health care agencies are taking a toll on continuing education attendance and funding. One segment most affected is that derived from out-of-town attendees who are burdened with travel and per diem expenses. Many continuing education programs are experiencing a decrease in the number of participants per offering, which results in a corresponding decrease in income; at the same time, continuing education expenses are rising.

Now, more than ever, it is necessary for the continuing education director to incorporate a thoughtful, positive management plan to accomplish successfully the goals of the program. Three major elements of this plan include analysis, allocation, and decision-making. Each administrator needs to use a liberal amount of each element, with a financial outcome perspective. A financial analysis of continuing education programming helps the director (1) review past and current facts; (2) assess how resources were allocated, and how they should be allocated in the future; and (3) differentiate which products, staff activities, and cost areas yield greater or lesser results. The plan for the future incorporates the results obtained from this assessment.

There are various methods to sponsor continuing education. Among the most commonly used methods are:

Full sponsorship. The continuing education program accepts full responsibility and risk for the offering.

Co-sponsorship. Two or more parties agree on a pre-negotiated work, risk, and profit-sharing arrangement.

Gratis. The offering is planned to meet specific needs of the nursing community at large. A nominal fee is assessed participants.

Collaboration. An agency participates in the planning and implementation of an offering, however, complete financial risk is absorbed by the continuing education program.

Contract. An agency enters into an agreement for purchase of a specified service or group of services to be provided by the continuing education department. (Contractual services may not include offerings. All consulting services are covered by contractual agreement.)

Contract with accompanying co-sponsorship. This arrangement is similar to a contract, but there is an agreement to open the program to out-of-agency participants.

## Considerations in Pricing A Contract

Pricing a contract is altered by the specific services to be performed. An accurate estimate of the time and cost of all activities is essential. These activities include needs assessment, planning, designing, implementing, monitoring, evaluation, follow-up, record keeping, supplies, reproductions, registration, travel, honoraria, and correspondence. A category not to be overlooked is the cost of making and selling the contract. The director needs to estimate the cost of all personnel who will be involved in these tasks and to include all overhead costs in the price.

The amount charged will depend on many factors, including policies of the university, ability to interpret the benefit of services to the agency, the client's ability to pay, the intent for specific programming with different agencies, the quality of the offerings, and the overview of programming.

## What to Include in a Contract or Letter of Agreement

It is advisable to consult the university's legal officer for guidance regarding specific criteria of a contract. All contracts or letters of agreement include at least the following seven criteria:

1. Identification of parties
2. Activities for which each party is responsible
3. The subject matter
4. The time element
5. Delivery or performance criteria
6. Remedies for breach or damages
7. Cancellation policy

## Skills Needed to Plan and "Sell" Contracts

Continuing nursing education faculty are already masters of the most diverse set of skills in nursing. Contracting requires the development of at least two additional skills. One of the most essential is the ability to accurately estimate the cost of the entire contract, including direct and indirect costs and profit. It may be necessary to rethink philosophical attitudes toward staff time expenditures in relation to cost.

The other advantageous skill centers around selling the contract. Personal selling is probably the least used continuing education marketing technique, yet it is critical in contracting. Many agencies may desire services, but are unwilling to take the risk. Techniques of the professional salesperson are extremely helpful to interpret the benefits of the contracted services to staff development and nursing service directors who may be unaccustomed to the negotiating process and/or making decisions involving large sums of money.

## Advantages of Contracting

The advantages of contracting for the continuing nursing education program are:

- More economical utilization of resources, especially staff time;
- Reduced cost of presentation due to lack of advertising;
- Less time involved on part of coordinator;
- More effective evaluation of outcomes, both formative and summative;
- Elimination of attendance uncertainty (attendance usually becomes the responsibility of the agency);
- Number of learners per offering (essentially the same in contract and non-contract offerings).

The contracting agency benefits from:

- The design of an offering specific to the needs of learners employed by the agency;
- The development of support systems within the agency that enhance implementation of new ideas;
- Affiliation with a university;
- Effective recruitment and retention tool;
- The diverse contracted services, e.g., needs assessment and evaluation of service;

- An enhancement of staff development programs;
- The expression of concern and interest in agency personnel;
- The provision of continuing education units and continuing education in recognition points;
- More efficient allocation of training staff to meet in-house educational needs;
- A broad and positive exposure in a highly competitive recruitment arena;
- Record keeping and processing.

## Disadvantages of Contracting

Contracting, without full explanation, appears expensive to the agency. It is difficult dealing with staff development and nursing service directors who feel uncomfortable discussing large sums of money. It is equally difficult for continuing nursing education directors and faculty who are inexperienced in negotiating financial aspects, such as costing and projecting profit, or who may lack "selling" skills. The continuing nursing education program that offers only contracts limits the audience it serves. It will not serve the needs of those nurses in the community who are not participants in contracts.

In sum, contracting is a powerful sponsorship alternative that increases the efficiency of the overall continuing education program. It provides the mechanism for the most economical allocation of staff time while yielding a high return on investment. Contracts are a highly effective means for meeting the continuing education needs of health care professionals--more than open programs, since specific agency problems can be analyzed, solutions proposed, and in-house support groups developed.

The drawbacks with contracts center around the inexperience of continuing education faculty and agency administrators in the negotiation process and cost/benefit relationship.

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# Associate Degree Education: Are the Parameters Real?

Associate degree nursing education has clearly arrived. In the process of a literature review in preparation for this paper, the paucity of literature within the last several years on the parameters of associate degree education was striking. This could mean that the issue of survival, if not settled, at least had decreased in controversy from earlier years. Associate degree graduates are functioning and accepted as integral members of the health care system.

Given that associate degree graduates are accepted, the next issue is that of utilization of these graduates. What parameters, if any, distinguish the associate degree graduate from graduates of other types of programs? What are the distinguishing characteristics of the educational program itself? Are these characteristics transferred into the practice setting? The parameters of associate degree education are explored from a historical perspective, in terms of what the literature says regarding the parameters of this type education and practice, and by the performance and utilization of its graduates.

## Historical Development

World War II, as is true for all wars, served as a turning point in history. With the greatly increased need for nurses, nursing education programs came under scrutiny as never before. The formation of the Cadet Corps and the first federal support for nursing education brought nursing programs a needed, outside perspective. Curriculum changes were made to meet federal standards. These changes included, among others, modifications in the use of time as a curriculum guide.

The postwar years provided an even more fertile climate for change. Mildred Montag and the associate degree nursing program became the cutting edge for much of this change. Several factors were instrumental in bringing this about.

Immediately following the war, Esther Lucille Brown, a social anthropologist, made a survey of nursing schools all over the country. Her findings were published in a book called *Nursing for the Future*. The recommendations of this book shocked the nursing world. Among other conclusions, she stated that most of what went on in hospital-based diploma schools of the day could not be labeled education. She urgently advised that nursing education move out of the hospital and into the mainstream of the educational system.

During this same period, the community/junior college concept was taking hold. Technological advances brought about by the war changed the work world creating a new type of worker — the technician. Community colleges were developing educational programs for technicians in a variety of fields. Initial negotiations began between the American Association of Junior Colleges and the National League for Nursing Education to explore the education of nurses within this setting.

Very few nursing programs of this era had collegiate ties. The vast majority of the programs in 1948 were hospital-based diploma schools. Waters described the schools of this era as follows:

> Most of the classroom teaching took place in the first year and decreased markedly by the third year. Lectures were given by doctors and 40-48 hours per week were spent on the hospital wards, where student services were essential. The program was repetitive and frequently of low quality. The conceptual framework was based on hospital geography. Students were selected within a very narrow range of population: 18 to 25 years of age, white, female, and single. Faculty were, by standards held for college teachers at the time, woefully underqualified. The major part of the students' learning experience was determined and evaluated by hospital ward personnel, not by designated faculty (Waters, 1978).

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*A paper presented by Julia Perkins at the September 1983 regional conference of the Faculty Development in Associate Degree Nursing Education, a three-year project administered by the Southern Regional Education Board and funded by the W. K. Kellogg Foundation of Battle Creek, Michigan. Dr. Perkins is chairperson of the Department of Nursing at Kennesaw College in Marietta, Georgia.*

It was against this background that Montag, in connection with her doctoral dissertation at Teachers College, Columbia University, developed a proposal for a new nursing program, Education of the Nursing Technician. This program would be centered in the college with decisions regarding the program lying with college personnel. Curriculum, rather than being geographically based, would be based on what nurses do, i.e., address patient problems. This idea of a conceptually based curriculum was a radical departure from the then current practice.

Another radical departure was in relation to students. In line with the open door philosophy of the community college, the doors of nursing education were opened to a new group of students — older, married, more settled men and women. Student class load was to be no different for nursing students than for other students. Faculty were to be hired, evaluated, and promoted on the same criteria as other faculty within the college. These reforms are now so acccepted that it is difficult to imagine that it was ever different.

It is also hard to imagine a greater success. The idea has become a national phenomenon. In 1976 there were 642 associate degree (AD) programs as compared to 390 diploma programs and 341 baccalaureate (BD) programs (Waters, 1978). Statistics regarding the growth of admissions and graduations from the various types of programs are even more revealing. From 1961 to 1980, the total number of admissions to nursing programs of all types increased 115 percent, admissions to baccalaureate programs increased 308 percent, diploma admissions declined 44 percent, and admissions to associate degree programs increased by 2,474 percent (see Table 1). The statistics on graduates show the same trends. While total number of graduates increased in this period by 152 percent, baccalaureate graduates increased by 520 percent, diploma graduates declined by 58 percent, and associate degree graduates increased by 3,828 percent (see Table 2).

The productivity of the associate degree graduate has also been demonstrated. The NLN Nurse Career Pattern Study (Knopf, 1980) shows that 10 years after graduation, 68 percent of associate degree graduates were employed in nursing positions. Furthermore, 61 percent of this group had worked for eight of the past 10 years. Twenty-five percent had completed or were working on a baccalaurate degree. Johnson and Vaughn (1979) found the longest, least interrupted work records among graduates of associate degree programs.

## Literature Review

Montag conceived of the nursing technician concept based on her analysis of practice which she described as follows:

> The functions of nursing can be said to be on a continuum or to have spectrum-like range. At one extreme of the range of the spectrum are those activities which are very simple and which serve to give assistance to the nurse or the physician. . . . At the other extreme of the range of function are those activities which are extremely complex and which require a high degree of skill acquired through long periods of training. . . . The main volume of nursing in hospitals, clinics, and other agencies lies somewhere in between the two extremes just described. They occupy the middle of the spectrum range—and may be described as semi-professional or technical (Montag, 1959).

While the terminology has changed over the years from "technical nurse" to "associate degree nurse," the issue for nursing education has remained the same. What are the parameters that define the practice of this associate degree graduate? How does his/her practice differ, if at all, from that of other levels of nurses?

In an early report Montag defined the functions of the associate degree nurse as:

1) to assist in the planning of nursing care for patients;
2) to give general nursing care with supervision; and
3) to assist in the evaluation of nursing care given (Burnside, 1974).

The original assumption was that the graduate was a generalist and working under the supervision of a professional nurse.

Matheny (1974) early on attempted further delineation of these parameters. She said that limits on the scope of function, depth of knowledge, interpretation of practice, and influence on the course of practice constituted discriminants upon which differentiation of practice could be based.

**Table 1**

**Admissions to RN Programs, 1960 and 1980**

| | 1960-61 | 1979-80 | Percent Change |
|---|---|---|---|
| Total Number of Admissions | 49,219 | 105,952 | 115 |
| Number of B.S. Admissions | 8,674 | 35,414 | 308 |
| Number of A.D. Admissions | 2,085 | 53,633 | 2,474 |
| Number of Diploma Admissions | 38,466 | 16,905 | −44 |

Source: Adopted from National League for Nursing Data Book, 1981.

**Table 2**

**Graduations from RN Programs, 1960 and 1980**

| | 1960-61 | 1979-80 | Percent Change |
|---|---|---|---|
| Number of Graduates | 30,019 | 75,523 | 152 |
| Number of B.S. Graduates | 4,031 | 24,995 | 520 |
| Number of A.D. Graduates | 917 | 36,034 | 3,828 |
| Number of Diploma Graduates | 25,071 | 14,495 | −58 |

Educators quickly found that these early broad guides gave little direction for the selection of learning experiences that are appropriate for these students. During the following years a variety of authors (Chater, 1969, 1970; Matheny, 1969; DeChow, 1969; Waters, 1978; Moore, 1969; McDonald and Harms, 1966; Johnson, 1966; Robischon, 1972; Chioni and Schoen, 1970; Michelmore, 1977) have attempted to look theoretically at the practice of associate degree graduates. Their practice is most often described in comparison with practice of professional or baccalaureate degree graduates. The culmination of these efforts are the statements that were developed by both the American Nurses' Association (Educational Source Book, 1980) and the National League for Nursing (Competencies, 1978) which describe in detail the competencies of different types of practice. Waters (1978) proposed a framework for the examination of these parameters that consists of the following elements:

1) definition of the client served;
2) the problems the nurse addresses;
3) the interventions that characterize the practice;
4) the context or setting in which the practice occurs;
5) the characteristics of the work-world relationships; and
6) the goals for nursing care.

**Client**

Educators have generally agreed on the definition of the appropriate client for the associate degree nurse. Waters (1978) as well as the ANA (1980) and the NLN (1978) competency statements agree that the individual is the appropriate client for this type of nurse. Waters (1978) elaborates by saying that even though these graduates deal with a group of patients, they deal with them and their needs on the basis of individuals. Even though family members are often involved, services are related to the experience that the individual is having and the impact of his illness on relationships with others. The baccalaureate graduate, on the other hand, defines the client to mean not only an individual but groups as well. These groups might include both the family and the community where the nurse interacts with the group as a focus instead of a number of different individuals.

Another parameter of the appropriate client of the associate degree nurse was addressed by Waters (1978) who stated that the competence of the associate degree graduate is confined to those clients who are at home in the dominant culture of the nurse and the health care delivery system of the community in which the program resides. This parameter is further supported by the *NLN Criteria for the Evaluation of Nursing Programs Leading to an Associate Degree in Nursing* (1977). These criteria require that cultural diversity be addressed within the curriculum but accept the definition of the diversity that exists within the community itself. The baccalaureate graduate, however, should be familiar with a broader range of cultures (Waters, 1978).

**Problems**

In terms of problems addressed, virtually all authors (Chater, 1969; DeChow, 1969; Matheny, 1969) agreed that the associate degree graduate addresses common, recurring problems that have predictable outcomes. Matheny (1969) also specified that these problems can be either physiological or psychological in nature. Waters (1978), on the other hand, stated that the problems for the associate degree nurse are more appropriately physiological than psychological, as physiological problems are better defined. The competency statements of both the ANA (1980) and the NLN (1978) further delineated that: 1) basic needs are an appropriate focus for the associate degree nurse; and 2) the associate degree nurse selects a nursing diagnosis from an established list. In contrast, a baccalaureate graduate, while also addressing basic needs, is competent to establish a nursing diagnosis and is capable of handling less common problems.

An additional dimension of problems was addressed by Chater (1969) who said that decision making for the associate degree nurse was based on specific scientific principles. The baccalaureate graduate, on the other hand, often must make decisions in the face of incomplete knowledge and with uncertainty. She must handle situations with multiple variables and alternative solutions (Johnson, 1966).

**Interventions**

Some parameters have been delineated when interventions are discussed. Waters (1978) characterized these interventions as those which were commonly used by registered nurses with patients who are diagnosed and are under care in the health care system. As these measures are better defined and organized in physiological illnesses, graduate competencies emphasized interventions related to physiological problems. The ANA (1980) competency statement for associate degree nurses specified that the interventions are those that follow established protocols. DeChow (1969) added the additional parameter of predictable results. NLN competencies (1978), while including psychological interventions as an expectation of the associate degree nurse, limited this competence to the one area of promotion of psychological safety. Physiological interventions, on the other hand, encompassed 13 different areas.

In contrast, while competency statements do not speak specifically to interventions that are a part of the baccalaureate nurse's competency, it can be assumed that these interventions would include those specified for the associate degree graduate. In addition, more extensive interventions for psychological problems as well as those that are less common and without protocols might be considered a part of the baccalaureate graduate's practice repertoire. An example might be that, according to the ANA competencies (1980), the associate degree graduate is able to evaluate and modify her own communication with others while the baccalaureate graduate should evaluate and modify not only her own communication patterns but also those of others.

**Context**

The context or setting of associate degree practice has been more extensively discussed. Waters (1978) stated that the setting must be one where a nursing service is

established and structured, and the needs and demands for nursing are visible and defined. This is further supported by the NLN competencies (1978) which stated that the practice of associate degree nurses is generally limited to acute and extended care institutions. The ANA's *Source Book on Educational Preparation for Nursing* (1980) described the practice of associate degree nurses as limited to secondary care institutions. The baccalaureate degree graduate on the other hand, according to the NLN's *Characteristics of Baccalaureate Graduates* (1979), is prepared to function in a variety of health care settings such as hospitals, homes, and community. Robischon (1972) stated that baccalaureate graduates should be able to function in new and evolving health care settings. The ANA *Source Book* (1980) designated primary, secondary, and tertiary care institutions as appropriate settings for the baccalaureate graduate.

**Work Relationships**

Within work relationships, new ideas have evolved from Montag's original formulations. Both the ANA (1980) and the NLN (1978) competency statements agreed that there are two elements to this relationship:

1) The associate degree graduate should work under the guidance of a person with greater expertise. ANA's statement designated this person by educational credentials while the NLN statement spoke to experience level as the identifying credential.
2) The associate degree graduate should be able to direct others in the performance of patient care.

Waters (1978) was in agreement with this by specifically delineating that the management role of the associate degree graduate was limited to seeing that the client gets the care that he/she needs. Baccalaureate graduates on the other hand are defined by the NLN *Characteristics of Baccalaureate Education* (1979) as being responsible for working collaboratively with others, effecting needed change within institutions, and accepting responsibility for effecting care through others. The ANA competencies (1980) also delineated staff development as an appropriate function for the baccalaureate nurse.

**Goals for Care**

The literature revealed more dissent regarding goals for nursing care at the associate degree level. Waters (1978) as well as the NLN competency statement (1978) limited the goals to illness problems as opposed to health problems. Chater (1970) limited associate degree practice to short term or immediate goals and actions. This position is supported by both the NLN (1978) and the ANA (1980) competencies in regard to teaching plans, but not in regard to goal establishment. The baccalaureate graduate, however, is involved in both long-term goal setting (ANA Competencies, 1980) and problems related to health as well as illness (NLN Characteristics, 1979).

**Commonalities**

It is perhaps also important to discuss commonalities. Technical and professional practice or associate and baccalaureate practice are not viewed as discrete entities but as one entity encompassing the other, i.e., one circle placed inside the other. Thus, there is a core of common practice. The nursing process is central to all levels of nursing practice. In addition, all graduates should have a core of well developed basic nursing skills. All graduates must be accountable for their own actions within their level of expertise and for contributing to the overall quality of nursing care. Finally, all graduates participate in the roles of care giver, communicator, teacher, manager, member of a profession or discipline, and investigator.

## Parameters of Practice

It is apparent that much work has gone into the delineation of these parameters. Additionally, these same parameters have been widely adopted by educators for use in curriculum decisions. How useful are they in practice settings? Do they indeed define realistic parameters of practice? Are the commonalities greater than the differences? Students seem to view some differences at least in a general way. A 1974 study (Bullouch and Sparks), designed around the care/cure concept, found that 70 percent of the baccalaureate students and 42 percent of the associate degree students were oriented to the "care" function of nursing. Thirty percent of the baccalaureate students and 58 percent of the associate degree students were oriented around a "cure" focus. While these figures certainly do not represent a dichotomy, they do offer some support to the more physiological orientation of the associate degree nurse and the increasing psychological focus of the baccalaureate nurse. Dennis and Jenkin (1979) concluded in a review of the research on the relationship between education and practice that, while the results of these studies have been inconsistent, performance can be differentiated in a number of ways. As a result of their review, they concluded that initially the associate degree and diploma graduates are equal or superior to baccalaureate graduates in the competencies involved in the performance of routine nursing duties. Associate degree graduates were found to be less proficient than baccalaureate graduates in the areas of "coordinative ability, innovation, initiative, breadth of knowledge, follow-up activities, and ability to apply knowledge to problems." A committee of the American Society of Nursing Service Administrators saw no significant differences for the beginning practitioner (England, 1978). A study by Waters and others (1972) found that distinctions in practice according to educational level were not found consistently in all practitioners. This finding led them to speculate if differences are educationally based or based on what Chater (1968) called differences in style that are not related to knowledge base. Sheahan (1972) felt that there are several levels of nursing education but only one level of practice.

What of the importance of setting? The majority of nurses, 73.6 percent (Source Book, 1974) are employed in acute or extended care facilities. Most of the research related to practice distinctions has been conducted within these agencies. Most of these agencies would seem to have the same expectations of all new graduates. In the Atlanta area, for example, institutions that employ both associate degree and baccalaureate nurses make little or no distinctions in terms of compensation and none in terms of job descriptions, based on the assumption that all are registered nurses.

Kruger (1972) supported this practice of equal pay when he stated that the Civil Rights Act was interpreted by the Equal Employment Opportunity Commission to prohibit the use of any "test" that adversely affects hiring, promotion, transfer or other employment opportunity unless the test is highly valid or unless other procedures or criteria for hiring are unavailable. These guidelines include specific educational backgrounds as an example of a "test." If the job descriptions and classifications for levels of education are the same, then, according to this author, differing pay scales are illegal.

Additional research relating to setting of employment were Kramer's (1969, 1971) hallmark studies that found that nurses with a high professional orientation, i.e., high value for decision making, individualized care, and problem-solving skills, experience more conflict and are more likely to leave hospital employment and nursing. Waters (1972) found that baccalaureate graduates who did exhibit behavior defined as professional were practicing in hospitals that had large numbers of baccalaureate graduates and where the nursing leadership strongly supported these types of behaviors as a component of practice.

Based on these studies it would seem that the following assumptions could be made:

1) Hospitals tend to have similar expectations and rewards for all new graduates.
2) Nurses who exhibit behaviors considered to be "professional" have a low level of satisfaction unless there is considerable support from both peers and leadership for these behaviors.
3) Many of the investigations regarding distinctions of practice have occurred within the hospital setting.

Given these assumptions, is it unusual that distinctions of practice are blurred? Returning to the associate degree parameters of practice, does not the new graduate of any program employed in a hospital—

1) deal with common recurring problems of clients? Except in specialty hospitals, such as pediatrics or burn units, the vast majority of hospitalized people have these types of problems.
2) deal with individual clients? The individual is, by definition, the focus of care in these agencies. Families are generally considered in terms of their impact on or support of this individual.
3) deal mainly with illness problems that are physiological in nature and require physiological interventions? Clients are hospitalized, except in psychiatric hospitals, because of physical problems defined by their physician. Interestingly, in psychaitric hospitals, associate degree and baccalaureate nurses are often employed for different purposes and function in different ways.
4) deal mainly with short-term goals? Does not the very structure of the hospital as it deals with episodic care largely concern itself with relatively short-term goals?

The parameters of associate degree education are real. These parameters encompass the parameters of practice as they are realistically encountered by the beginning practitioner in hospitals, the institutions that employ the largest numbers of nurses. This phenomenon would explain the success of these programs — a realistic product for a realistic market. Perhaps the studies that compare the performance of associate degree and baccalaureate graduates within this setting cannot answer the questions of differences in practice. If the baccalaureate competencies are not required, how can they be evaluated? This could be compared to examining the performance of statisticians and data processors on a job where the performance is largely geared to data processing. Few differences could be predicted.

These remarks are not meant to be construed that nursing practice that includes the parameters of baccalaureate practice cannot or does not occur in hospitals. Leadership positions require the staff development and change agent skills characteristic of baccalaureate practice. Specialized units deal with individuals whose problems are indeed complex and unique. For example, psychiatric nurses deal with groups of people where the focus is on the group, and attempt to influence their communication patterns. Less structured settings, such as wellness centers and hospices, require many more independent judgments. Instances of situations requiring these skills occur in hospitals and all units as well. They do not, however, constitute the majority of the practice context and, thus, are often lost in subjective evaluations of performance.

For the parameters of practice to emerge clearly, the settings must involve a situational context where a range of practice behaviors are required and occur with some frequency. Therefore, two recommendations are that:

1) Hospitals or acute care institutions delineate levels of practice based on a needs assessment of various units. Some hospitals might assess a need for all associate degree nurses, except perhaps on critical care areas and in leadership positions. Others, such as children's specialty hospitals, might assess a need for all baccalaureate nurses. Many institutions are moving toward this differentiation due to increasingly sophisticated levels of care.
2) Further research on practice behaviors of various levels of graduates be conducted where a range of practice behaviors are required.

In conclusion, the value of Montag's associate degree nurse has been demonstrated beyond doubt. History shows its positive effects upon nursing education as a whole, both for curriculum and for student policies and practice. Associate degree graduates can be shown to be practicing within realistic parameters for a realistic work environment. The next step is to use our knowledge to help differentiate the parameters of practice as we know they exist within work environments. Baccalaureate and associate degree nursing are both valued and needed. We must work together, as educators and as representatives of the health care settings, to demonstrate these differences. At stake is the future of nursing.

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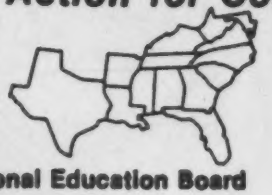
## *Regional Action for Continuing Education in Nursing Project*



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# QUESTIONS AND ANSWERS ABOUT THE CONTINUING EDUCATION UNIT

### What is a Continuing Education Unit (CEU)?

The Council on the Continuing Education Unit defines one CEU as ten contract hours of participation in an organized continuing education experience under responsible sponsorship, capable direction, and qualified instruction. This definition, along with many more details about administering, reporting and evaluating continuing education through use of the CEU, is contained in *The Continuing Education Unit: Criteria and Guidelines*, available from the Council on the Continuing Education Unit, 13000 Old Columbia Pike, Silver Springs, Maryland 20904. Similar information, as well as model plans for using the CEU, is available in *The Continuing Education Unit: Guidelines and Other Information*, The Commission on Colleges, Southern Association of Colleges and Schools, 795 Peachtree Street, N. E., Atlanta, Georgia 30365.

### What is the Purpose of the CEU?

The primary purpose of the CEU is to provide a permanent record of the educational accomplishments of an individual who has completed one or more significant non-credit experiences.

### Who Can Award the CEU?

CEU may be awarded by a college, association, company, hospital, agency or other organization that is willing and able to meet each of the criteria established for the use of the CEU. The CEU cannot be awarded for any offering or course taken for credit. The sponsoring agency must have control of its entire program, provide or arrange for appropriate education facilities, including classrooms, library, and reference materials, as well as all necessary teaching equipment, keep permanent records of all participants and make a transcript of records available to any participant who requests it.

### How Many CEU Should be Awarded for a Program?

One CEU is awarded for each ten clock hours of instruction involved in the program. Instructional clock hours do not include time involved

-over-

in coffee breaks, meals, social activities or business and committee meetings.

Can We Award CEU for Our Inservice Training Program?

Those programs that impart general or technical information which is applicable to the professional or technical field and will be of value wherever the individual is employed are appropriate for the awarding of CEU. Programs that relate to organizational procedures and policies are not eligible for CEU.

Does the CEU Equal Academic Credit?

No, there is no relationship between the two. By definition the CEU relates only to non-credit continuing education. It is not appropriate, therefore, to consider CEU in connection with academic credit.

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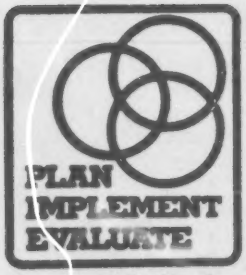
# THE DELIVERY OF CONTINUING EDUCATION

A paper presented by Frances P. Koonz
at the Career Mobility Conference
sponsored by the Southern Regional
Education Board Curriculum Project
on December 18, 1980.




Regional Action for
Continuing Education
in Nursing

The delivery of educational opportunities for nurses through organized non-credit continuing education programs is a relatively recent addition to nursing education. The initial involvement of universities and colleges in continuing education was infrequent and sporadic until 1959, when federal funds became available for short-term courses.

In June, 1969, the deans and directors of the Southern Regional Education Board Council on Collegiate Education for Nursing were asked to provide information concerning the numbers of nurse faculty with ongoing responsibility for continuing education who devoted 50 percent or more of their time to planning, implementing, and evaluating such programs. Twelve faculty, nine full-time and three part-time, were identified.

In the decade following that survey, virtually every university-based school of nursing and many colleges in the Southern region established programs of continuing education with at least one faculty member with full-time responsibility for the program. During that 10-year time frame the continuing education movement has mushroomed nation-wide and a variety of providers outside the collegiate setting, with varying degrees of expertise in nursing education, have been selling their wares in the continuing education market. In short, a quiescent voluntary opportunity of only a few years ago has erupted as the vanguard of an age of accountability in nursing. I speak, of course, of the effort toward mandatory continuing education as a prerequisite for nursing relicensure currently operative in some 13 states which must bear some responsibility for the smorgasbord of continuing education opportunities available to nurses today. Yet in some geographical areas and among some groups of nurses, meaningful continuing education relevant to practice is still unobtainable. Consequently, the delivery of continuing education and the inherent inequities need careful scrutiny by nursing educators in all settings.



NCE: 1881

But there is also a more basic question that needs resolution. Welch,[1] in a recent article in the Journal of Continuing Education in Nursing questions the motivation of nurses to update their practice. "Why," she asks, "has it been that nursing has failed to fulfill requirements of self responsibility to attain increased skills and knowledge in an ongoing manner to maintain standards of professional practice? Are the obstacles or deterrents to continuing education in nursing intrinsic or extrinsic to the learner?" Is the underlying problem not one of motivating nurses to update their practice? You and I well know that, even in areas where continuing education opportunities exist in overwhelming numbers, there are nurses who literally need to be pushed to avail themselves of these opportunities. If the deterrents are intrinsic--within the nurses themselves--delivery systems will not impact upon those individuals.

Cooper[2] feels that, in some instances, entry-level nursing education may be at fault. She states, "Historically, faculty members in schools of nursing have failed to instill in their students the necessity of lifelong learning for professional practice. The well-worn cliche 'once a nurse, always a nurse' reflects a negative attitude toward change and toward learning." Related to the basic nursing preparation may be a lack of encouragement for introspection in regard to assessment of professional and personal growth. O'Conner[3] advocates examining one's present level of practice competence and future professional goals and professional awareness; identifying those nursing activities that one tends to avoid, or make one uncomfortable; and assessing skills one wishes to improve or knowledge that seems superficial.

However, even if the nurse has a positive attitude toward learning and is motivated to improve and update her practice, the setting in which she practices can also be a deterrent. Learning implies a dynamic rather than a static state and utilizes change as its primary mechanism of action. Change requires risk-taking and produces feelings of vulnerability. If a nurse is functioning in a setting enamored with the status quo, in which the climate is not conducive to learning, where staff are not encouraged to question their own practice, and where there is reluctance to put new knowledge and skill into practice, the nurse will see her continuing education endeavors as fruitless. I submit that so long as we measure the effectiveness of continuing education in hours of attendance and do not foster the individual nurse's introspection regarding her specific learning needs and do not foster the expectation of improved clinical practice, the delivery system for continuing education will have no impact. Nurses will continue to shy away from continuing education programs or, at best, will sit through them in order to earn the necessary continuing education units or contact hours. And those of us involved in providing continuing education will be producing "much ado about nothing," for the heart of the matter in continuing education in nursing is application in practice.

Responsibility for the process of continuing education then is a shared responsibility involving the individual nurse, entry-level nursing education programs,

employers, and continuing education providers. An effective delivery system to support the process is also a shared responsibility. In From Abstract Into Action, the National Commission for the Study of Nursing and Nursing Education[4] recommended the inclusion of continuing education in the statewide master plans. The Commission suggested that the master planning committees were in a unique position to assess the needs and resources of large planning areas for continuing education in nursing and then to apply these findings to a matrix of geographical and institutional givens. This suggestion has been implemented in a number of states. A recent publication, Indiana Statewide Program for Continuing Education in Nursing (ISPEN),[5] is an experience document which outlines the organized progression of a statewide system from conception through implementation and ongoing evaluation, from 1974 to the present. The ISPEN model has been used in a variety of ways by other states and organizations and is a delivery mechanism that provides a perpetual refueling system which serves the whole and each of its parts in a positive way. I recommend its study to you.

The National Commission also suggested regional planning for many aspects of continuing education through such vehicles as Southern Regional Education Board's current Continuing Education project. One of the project's goals is delivery of continuing education for those specialized groups of nurses whose needs can be more feasibly met at the regional level rather than the state level.

One of the most complex problems in any system of delivery of continuing education is that of providing relevant programs to nurses in a variety of roles and with differing educational backgrounds. Until recently, most continuing education opportunities were geared to the needs of the nurse providing direct patient care. Perhaps the assumption was--and rightfully so--that the administrators and educators were being prepared at the graduate level. But, as Smith[6] points out, if the administrator of an organization is managing by skills acquired 10 years earlier can he or she ensure that the organization is operating at its most optimum level? With such rapid pace of obsolescence taking place, can the administrator function effectively without a planned continuing education program designed to assist him or her with the responsibilities of administration? And are not similar questions valid when asked of the educator? Smith describes educators as "decision makers, planners, organizers, standard setters, negotiators, counselors, facilitators, and evaluators. They have the tasks of delineating the philosophy and objectives and theoretical framework of the curriculum. They decide which theories of learning and motivation are most applicable. They determine what educational methods, techniques, and devices enable them to best achieve their goals. They decide when and where principles of other disciplines are best integrated. They are responsible for preparing and educating the nurse practitioner who will be directly responsible for meeting the needs of the consumer."[7] Should not continuing education for both educators and administrators be oriented toward improving their potential as leaders who can deal with the complex and diversified problems of nursing education and service as they exist today?

There are other groups whose needs for specialized continuing education must be met--the primary care nurse practitioners, the clinical specialists, emergency room nurses, and nurses employed in occupational health settings or correctional institutions. These are but a few of the groups whose specific needs must be addressed in any delivery system of continuing education. And let us not forget the continuing education needs of the continuing educators. Those of us fortunate to be in the Southern region have participated in programs co-sponsored by the Council on Collegiate Education for Nursing and The University of Kentucky College of Nursing. The current continuing education project will sponsor a three-year program to enhance the knowledge and skills of continuing educators in the region.

I would like now to discuss various methodologies of delivering continuing education offerings to nurse learners. These are based upon assumptions about the adult learner as outlined by Knowles.[8] In brief:

(1) The adult learner is increasingly self-directed;

(2) The learners' experiences are a rich resource for future learning;

(3) The readiness to learn develops from life's tasks and problems;

(4) The orientation to learning is task- or problem-centered; and

(5) The motivation to learn is drawn from internal incentives.

The process elements in adult learning must also be a consideration in delivery of continuing education and include the following:

(1) The learning climate is informal, mutually respectful, consensual, collaborative, and supportive;

(2) Planning for the learning is by participative decision-making;

(3) Learning needs are diagnosed by mutual assessment;

(4) Goal-setting is by mutual negotiation;

(5) The learning plan is designed to include content and projects sequenced in terms of readiness;

(6) The learning activities include independent and group study and application; and

(7) Evaluation is by mutual assessment.

Integration of these assumptions and processes into a delivery system provides options that enable the continuing educator to use methodologies best suited to the circumstances of a given audience.

## Conferences and Workshops

Traditionally, conferences and workshops are the most frequently used approach to continuing education in nursing. The conference permits a pooling of various points of view and sharing of experiences that lead to joint thinking. It requires that participants contribute from their own knowledge and experiences. Demonstrations, lectures, role-playing and other simulations, and audiovisual media may all be used as a basis for conference participation. Workshops are also planned to involve the participants in specific tasks related to the subject. They are designed for persons with like experiences to study problems of mutual concern. Working sub-groups are organized around problem-solving situations. As its name implies, a workshop requires work, and the results can be in the form of specific plans for nursing interactions. One of the most successful workshop formats offers multiple sessions with opportunities for application of results to the practice area in the interim between workshop sessions. Feedback and peer support enhance the value of this modality. There are some drawbacks, however, in that the requirements to be away from the work setting and to travel to the conference or workshop site may not be feasible for nurses in geographically distant or under-staffed areas. Increasingly, regional networks, as described in the Indiana plan, or university-based outreach programs are attempting to bring these opportunities to under-served areas. In many instances, programs are repeated in the same area so that as many nurses as possible will be able to attend. The success of these traveling "road-shows" requires a good deal of planning and flexibility on both the part of the continuing education program and the workshop or conference leader. Costs can be a definite deterrent in some instances and, as alternate sources of funding become scarcer, other options must be considered.

## Educational Technology

The potential for the use of educational technology continues to expand. Nursing has been involved in the use of technology for continuing education for more than a decade. Closed circuit television, public broadcasting TV, and videotaped conferences have been used with varying degrees of success. An on-site coordinator, trained by the sponsor of the media program, enhances the potential for achieving learner objectives.

Satellite transmitted television has been successfully utilized to disseminate continuing education and research findings to practicing nurses in isolated areas. Again, funding for such programs is becoming scarce, and the future for broad-based satellite continuing education programs unpredictable.

The telephone network for educational purposes has been used successfully in a number of rural states since 1957. However, as with all approaches involving mass media, instructional benefits will vary with the congruency, consistency, and control integrated into the curriculum. Visual supplements require deliberate and careful planning, and the degree to which local discussions reinforce or expand the content presented depends upon the leadership available in the setting.

## Self-Directed Learning

The emergence of self-directed learning activities has been formalized in a 1978 document developed by the ad hoc Committee on Nontraditional Study for Self-Directed Learning, a committee of the ANA Council on Continuing Education. The document provides guidelines for structured self-designed learning projects to help achieve a uniform approach to this continuing education modality. The learning activities may be self-designed, in which the learner controls the majority of learning variables, or other-designed, in which the learner controls a limited number of learning variables. In either instance, the document provides suggested steps to assist the individual learner plan, implement, evaluate, and document the project. A self-directed learning activity takes into account individual learning styles and learning needs. Its greatest advantage is that it provides options to individuals for meeting specialized learning needs. Directors of continuing education and staff development programs will find this document especially helpful when providing guidance to individuals or groups interested in expanding their continuing education options. Not to be discounted as an added advantage, is the minimal financial outlay required by the individual nurse and/or the employing agency.

As the nursing profession continues to move toward more clearly differentiating between the competencies of nurses based upon educational preparation, the modes of delivery of continuing education will be more clearly defined. The continuing education needs of nurses prepared at the associate and diploma levels will differ from those prepared at the baccalaureate level. Nurses prepared at the graduate level will need to keep abreast of more complex nursing responsibilities. The delivery of continuing education will certainly undergo many more changes in the next decade to keep pace with, and be responsive to, the profession it serves.

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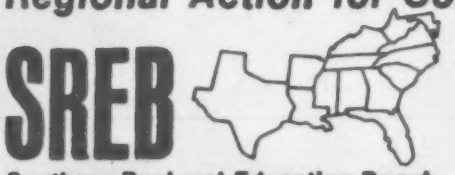
Note: Frances P. Koonz is the Director of Continuing Education at the University of Maryland (Baltimore), Chairman of the Continuing Education Committee of the Southern Council on Collegiate Education for Nursing, and member of the advisory committee for the SREB regional project.

## *Regional Action for Continuing Education in Nursing Project*

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### DEFINITIONS

Continuing education is a general term that, as Cyril O. Houle asserts, "implies some form of learning that advances from a previously established level of accomplishment to extend and amplify knowledge, sensitiveness, or skill."[1] The following definitions, developed by the Council on Continuing Education, American Nurses' Association, provide a common frame of reference for this regional project.

Continuing Education. Planned, organized learning experiences designed to augment the knowledge, skills, and attitudes of registered nurses for the enhancement of nursing practice, education, administration, and research to the end of improving health care to the public.[2]

Continuing Education Program. A separate and identifiable unit within the organizational structure of a nursing program or an educational setting that, under the direction of a designated person, focuses upon continuing education activities.

Offering. One segment of a continuing education program. It may be a single experience or activity or a series of experiences or activities.[3]

Staff Development. A term describing a process that includes both formal and informal learning opportunities to assist idividuals to perform competently in fulfillment of role and expectations within a specific agency. Resources both within and outside the agency are utilized to facilitate the process.[4]

Inservice Education. Learning experiences provided in the work setting for the purpose of assisting staff to perform their assigned function in that particular setting. Inservice education is one aspect of staff development; the terms are not interchangeable.[5]

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4. Ibid., p. 9.

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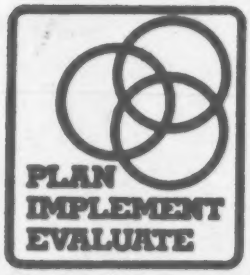



Regional Action for
Continuing Education
in Nursing

# BELIEFS ABOUT EVALUATION

Fourth Regional Workshop
Terrace Garden Inn
August 11-12, 1982

Continuing nursing education directors shared their beliefs about evaluation in a 1981 survey. This report summarizes some of the opinions that were submitted by project participants. In response to "Describe briefly your philosophy concerning evaluation" participants said:

> . . .continuing education should improve competence in practice. Evaluation should be directed toward measuring that improvement.
>
> . . .evaluation is a continuous process of collecting data to be used as a basis for applying a set of standards in making a judgment. It involves not only that which occurs as observable behavior but also the appraisal of the worth of the behavior through the exercise of judgment.
>
> Evaluation is a continuous process which begins with program planning. A realistic, workable evaluation plan is the key to a strong and viable program.
>
> . . .an integral part of CE curricula and individual program development. (It) should be used as a feedback mechanism for improving teaching/learning, to identify desired outcomes, e.g., changes in knowledge, attitude, and skills, and used to improve the process of program planning and implementation.

Evaluation is a process which should identify where you are and give direction for where you are going.

Evaluation is the process for determining the degree to which behavior is judged. (It) is systemic, objective, and continuous.

Evaluation keeps continuing education offerings current, attractive to the target population, and viable.

Evaluation serves as a road map to give direction, assist in decision-making, and demonstrate accountability.

Evaluation is an essential process if one is to remain in concert with the needs of the clients a program may serve.

. . .should be based on objectives for learning. Do not feel it is necessary to evaluate whether patient care improves.

Too often what is called "evaluation" is simply "head patting." Evaluation techniques that are motivational in their approach are more worthwhile.

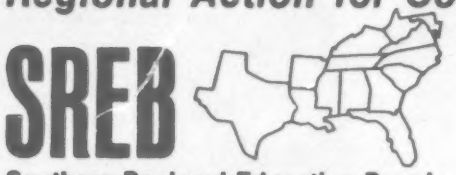
Evaluation is essential to assure that objectives are met, that a program has accomplished what was intended.

Ongoing process for providing feedback to instructors and to provide data base for planning both short and long term goals.

. . .evaluation is an essential component of education and appropriate tools must be developed to show that behaviors as well as attitudes are changed.

NCE: 1982

# *Regional Action for Continuing Education in Nursing Project*

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A SUMMARY OF
DISCUSSIONS ON COMPETENCIES
CONTINUING NURSING EDUCATION DIRECTORS NEED

*This summary presents pertinent information regarding the competencies needed by continuing education directors, the criteria for producing various offerings, and production problems. It is based on discussions in Track 1 (Production) during the spring 1982 regional workshop conducted by the Regional Action for Continuing Education in Nursing project. The workshop leader, Roberta Abruzzese,* synthesized the various discussions for use in this summary.*

## Competencies

The work exercise for competency specification was based on competencies developed by the American Society of Training Directors and the American Society of Health-Care Education and Training. Specific descriptors need to be developed for each area of competence required for the position of director of continuing education in college settings.

Competence--the quality or state of being competent--can be established through research, judgments of experts, task analysis, and group participation. Means of assuring competence include: licensure, continuing education, certification, peer review, accreditation of schools by professional organization, and approval of schools by the state.

The following seven steps are important factors in the development of competence: (1) choose a critical small topic, (2) review the literature for past five years, (3) organize a resource file, (4) synthesize ideas, (5) establish your own "system," (6) test your "system"--revise as needed, and (7) continue to read--stay updated.

Essential information needed for the development of competence includes: the identification of the area of competence required; needed knowledge, skills, and attitudes; and the learning strategies to be used in acquiring the specified competence. Among the specific behaviors related to leadership competency are the ability to: formulate policies, share responsibilities, prepare and monitor budgets, problem-solve, evaluate unit effectiveness, work cooperatively with others, and develop staff. The participants discussed in more detail the competencies needed for the following areas: design of continuing nursing education offerings, instructional techniques, evaluation, and needs analysis.

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**Roberta Abruzzese is the director of continuing nursing education at Adelphi University School of Nursing (New York) and chairman of the American Nurses' Association Council on Continuing Education.*

In sum, the continuing nursing education director needs knowledge of the principles of adult education, teaching modalities, instructional mission and philosophy, research, and theory of organizational behavior. The director needs the ability to identify essential content (need to know/nice to know), identify goals and objectives, select appropriate formats for the selected content, select techniques suitable for the content and audience, analyze and interpret data appropriately, and identify targeted populations. A competency self-rating scale can be used to determine the proficiency levels.

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## Criteria

What are the criteria for continuing education offerings provided by a community college as contrasted to those provided by a senior college? The group discussions indicate that the participants believe criteria evolves from the target population and the specificity of the topic. Community colleges, for example, might provide more offerings related to basic skills; senior colleges might explore ethical and theoretical issues in nursing practice, research, and education.

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*Alford, Harold J., editor. Power and Conflict in Continuing Education: Survival and Prosperity for All? Belmont, California: Wadsworth Publishing Company, 1980.*

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## Production Problems

Problems arise when methods and formats selected to achieve particular objectives are incongruent with the desired outcomes. For example, a book-based discussion is not the most appropriate method to effect change in skills. The following excerpt from The Modern Practice of Adult Education by Malcolm S. Knowles was used to demonstrate ways to avoid a major production problem.

| *Type of Behavioral Change* | *Most Appropriate Methods* |
|---|---|
| *KNOWLEDGE*<br><br>*(Generalizations about experience; the internalization of information)* | *Lecture, panel, symposium*<br>*Reading*<br>*Audiovisual aids*<br>*Book-based discussion* |
| *INSIGHT AND UNDERSTANDING*<br><br>*(The application of information to experience)* | *Feedback devices*<br>*Problem-solving discussion*<br>*Laboratory experimentation*<br>*Exams and essays*<br>*Audience participation*<br>*Case Problems* |
| *SKILLS*<br><br>*(The incorporation of new ways of performing through practice)* | *Practice exercises*<br>*Practice role-playing*<br>*Drill*<br>*Demonstration*<br>*Practicum* |

| | |
|---|---|
| *ATTITUDES*<br><br>*(The adoption of new feelings through experiencing greater success with them)* | *Reverse role-playing*<br>*Permissive discussion*<br>*Counseling-consultation*<br>*Environmental support*<br>*Case method* |
| *VALUES*<br><br>*(The adoption and priority arrangement of beliefs)* | *Biographical reading and drama*<br>*Philosophical discussion*<br>*Sermons and worship*<br>*Reflection* |
| *INTERESTS*<br><br>*(Satisfying exposure to new activities)* | *Trips*<br>*Audiovisual aids*<br>*Reading*<br>*Creative arts*<br>*Recitals, pageants* |

## Suggested Readings

*Adult Education Association.* *How to Use Role Playing and Other Tools for Learning.* *Washington, D. C.: Adult Education Association, 1955.*

*Knowles, Malcolm S.* *The Modern Practice of Adult Education.* *New York: Association Press, 1970.*

## Competency Self-Rating for Continuing Educators

Circle one number in each scale for your rating.

| Competency Area | Proficiency Rating Scale | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Beginning | | | | | | | | | Proficient |
| 1. Administration | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. Communications | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. Course Design | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. Evaluation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. Group Dynamics/Process | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. Instructional Techniques | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. Learning Theories | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. Audiovisual Equipment and Materials | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 9. Needs Analysis | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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**Regional Action for Continuing Education in Nursing Project**

**SREB**

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# CONTINUING EDUCATION: THE BUSINESS ARM OF NURSING EDUCATION

*In her keynote address for the regional workshop on management strategies for continuing education nursing programs, Pat S. Yoder Wise provided an excellent frame of reference for considering the issues. The content of the Lexington workshop and the underlying thesis of the Wise presentation were based on the premise that a continuing education program for nurses is a small business. The project staff believes the dissemination of the keynote address will help program directors and nurse administrative heads to recognize the relevance of small business management strategies in nursing education programs--not only continuing education efforts but also undergraduate and graduate programs.*

My comments are directed toward the continuing education business in academic settings. Rather than providing the definitions or tips, I will attempt to provide a philosophic perspective of the continuing education business in collegiate settings.

Do any of you recall a time when the phrase, "But nursing's different," seemed to dominate many conversations? Nurse educators explained that nursing "labs" were not scheduled as the chemistry or biology labs were, disrupted the established schedule with sequential day time frames, explained why the most recent automobile production research did not apply to care providers and why some of the typical, tried and true management strategies could not be placed into nursing service administration operations. Frequently, they were heard saying, "Yes, but nursing's different." They no longer say that because others now recognize that in some aspects nursing <u>is</u> different and that their ideas can be translated to other fields.

A similar state of development exists in continuing nursing education. These educators say, "Yes, but continuing education is different." Sometimes they use that phrase to lament their situations--Why do we have to generate our own money?--And at a rate much higher than regular tuition?--Why are we always the last to be scheduled into rooms and the first to be "bumped?"--, Why do we have to pay our own faculty or hire someone external to our own institution? Conversely, that same phrase is used to their utmost advantage. They can hire persons who might not meet traditional academic requirements because they <u>are</u> different. They travel more than other types of faculty because they <u>are</u> different. Many new and different topics, processes, and ideas can be facilitated in the continuing education program because, after all, it is different. Though delighted when one of the ideas (for example, practitioner education) is "bought" by the undergraduate or graduate nursing

faculty, dismay occurs when it becomes an integrated entity within its new home and is no longer viewed as appropriate in continuing education. Instead of being the mother, continuing education was merely the midwife and baby-sitter. It helps to recognize that continuing education programs are the testing grounds; someone else may accept and engulf some of the projects. There will always be the need for continuing education and one of its functions will always be innovation. In no other educational component can creativity be so limitless. Its business is to create and test and, in many cases, lead the way in new roles for nursing and new educational strategies.

Ask yourself what is the potential for innovation in the business sense of your operation? Do you believe you are a small business administrator? Perhaps answers to the latter question relate to your view of the world at a given time. For a moment, put on your hardest business hat and analyze some situations.

PUSHERS AND PREACHERS

While waiting for the national news on television one evening, I was struck by the fact that religion is as much a business as education or automobile production. Churches own massive amounts of real estate. Some own publishing firms, television and radio stations, and retirement centers. Many people say, "Yes, but they are different." Are they really? It was through a brief encounter with a particular religious program that I learned a new marketing strategy. Canada has had a mail strike for some time. Many of the religious programs rely heavily on donations or purchases of certain items to maintain their broadcasts. How could Canadians make these donations or purchases with a mail strike? Quite simply! All that was required was a telephone call to one's bank to instruct that bank to transfer money to a designated account at another particular bank. What unit on college campuses instituted the use of bank credit cards as payment for tuitions? Though bookstores accepted credit cards early, continuing education assessed adults' financial needs and instituted the charge card plans. So, is religion or education a business?

When I shared this observation with our dean, Teddy Langford, she recalled a country and western song--"Are You Ready for the Country?" by Waylon Jennings--that acknowledges that pushers and preachers are in the same business. Obviously some businesses are more acceptable than others, but diverse interests still form businesses.

BUSINESS OR NOT

When the following words are mentioned, do you think business or non-business: General Motors, American Telephone and Telegraph, nursing homes, hospitals, continuing education, schools of nursing, educational institutions? Reactions may differ from those of some non-continuing education colleagues or from those of persons not faced with financial realities. Regrettably, finances seem to be the aspect of an enterprise that causes people to classify it as a business or not. Yet business is more than merely finances.

Continuing nursing education program directors, by virtue of financial considerations, are using business relationships daily. As part of a college or university, they believe that educational concerns are foremost in any decision-making process. Yet, they must be cognizant of other implications. That framework differs from some businesses where profit is the primary concern. It is sometimes difficult for program directors to discuss an educational idea with colleagues who see it purely as such rather than also as a business venture. How often have you heard the question, "But what will

our community (or potential students) think of this approach?" Think of where the nursing profession might be with the infamous "1965 Position Paper on Nursing Education," if leaders had approached the issue as a marketing concern rather than as a logical educational point to be made.

Are some of the same business strategies used in continuing education applicable to the other programs in schools of nursing? For example, undergraduate nursing enrollments suggest business is down. Many schools are facing this problem directly and are using innovative approaches for recruitment and retention. Some of those strategies have been tested in continuing education programs; others have sprung from the urgent need to maintain enrollment levels. Suddenly, an educational institution is aware that it, too, is a business. It must sell its programs as being more beneficial than another educational institution's or some particular employment opportunity. Because continuing education programs have numerous community contacts, they can be invaluable in assisting with a problem that may eventually affect them. For instance, if they facilitate the return of nurses into formal education they may lose them temporarily as customers. If, however, programs select an internal marketing strategy that capitalizes on their ability to assist in program recruitment, they can compensate for that temporary loss.

STRENGTH IN DIFFERENCE

Continuing education directors need to analyze some of their strengths that stem from their differences, i.e., how do continuing education and undergraduate programs differ?

Associate and baccalaureate nursing programs tend to develop a needs assessment that helps document the initial need for a program. How often are these assessments reviewed? How often does the continuing nursing education program conduct some form of assessment? It makes sense, however, that faculty in continuing nursing education respond more quickly to changes simply because they are more acutely aware of what they are. Regardless of the amount of time spent in learning activities, continuing nursing education programs evaluate their offerings. Would any other academic program even think of conducting an equivalent number of evaluation processes?

Faculty in continuing education are very concerned with outcomes of their efforts. Outcomes are one important "product" of their business, but personal/professional satisfaction is another. As Phil Frandson said at the first national conference in 1979 on "The Business of Continuing Education," one of the approval criteria comes from the checkbook. Obviously, outcomes are important, but not at the expense of learner satisfaction. People are more tolerant of required activities than they are of non-required. Hence, returning participants have much more meaning to faculty in continuing education than do re-enrolled students in undergraduate programs. Because continuing education participants feel relatively free to meet their personal needs first and then "fit in" their educational activities, the checkbook measure takes on additional significance.

It is this financial aspect that places a continuing education program in a unique position in collegiate settings. While other programs are diminishing or remaining at status quo, non-credit endeavors, in general, have continued to grow. Continuing education programs are seen as a way to earn extra money or as a unit separate from that which is devoted to truly educational endeavors. If participation in continuing education held equal recognition as participation in other forms of teaching (i.e., it is part of one's teaching responsibility), educators must be prepared to market themselves to colleagues as well as to external publics.

Academic programs and continuing education programs should not be comparable. There are, however, common practices in each. They can be used to reaffirm or alter performance based on a cost-effectiveness decision basis. There are legitimate differences between academic and continuing education programs. Vive la difference!

There are also some differences between businesses and education. But, they are not mutually exclusive functions. One key difference is that the latter is more likely to say "no" despite an anticipated profit, if the endeavor is not compatible with its image and philosophy. This particular difference is also sometimes difficult for the community to grasp. It takes considerable fortitude to abide by our stated goals and philosophy when another provider is willing to "jump in."

It is important that directors of continuing nursing education programs enrich their abilities in the business of continuing education, help others recognize their expertise and apply these concepts to all programmatic endeavors. They are the ones who have the closest ties with the community, who provide the services to the taxpayers (the voters), who use marketing and other strategies in our management, and who involve people in opportunities that are designed to effect change. They already know that the business component of deciding courses to offer or materials to print is a matter of allocation of resources; many of their academic colleagues do not recognize this fact yet. Although many may not use a research proposal format, they do test their processes carefully to know which offerings to keep or discard. Is a similar process applicable to other aspects of nursing education, for example, ideas of "profit," such as community support, improved practice, and financial considerations?

In addition to using common business strategies in continuing education, program directors can provide direction to the undergraduate and graduate nursing programs. Making conscious decisions, analyzing the "industry," considering long-range forecasts and, as usual, being comfortable with a conceptual framework rather than with a defined plan can be applied in situations other than continuing education. Continuing education program directors are, in fact, the innovators of new practices, the responders to evolving needs, the people on the cutting edge. The unique and different characteristics of continuing education programs can facilitate, therefore, not only their own growth, but that of other programs. After all a continuing education program is not the only business arm of nursing education; it has simply been in the business longer.

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*Pat S. Yoder Wise is the Associate Dean, School of Nursing, Texas Tech, University Health Sciences Center (Lubbock, Texas).* *This presentation was given during the Second Regional Conference of the Regional Action for Continuing Education in Nursing, a three-year grant (PHS DU NU 24062) administered by the Southern Regional Education Board, in cooperation with the University of Kentucky College of Nursing, August 20, 1981, in Lexington, Kentucky.*